UNQUALIFIED DOCTORS PERFORMING COSMETIC SURGERY: POLICIES AND ENFORCEMENT ACTIVITIES OF THE FEDERAL TRADE COMMISSION—PART I

HEARING

BEFORE THE

SUBCOMMITTEE ON REGULATION, BUSINESS OPPORTUNITIES, AND ENERGY

OF THE

COMMITTEE ON SMALL BUSINESS
HOUSE OF REPRESENTATIVES

ONE HUNDRED FIRST CONGRESS

FIRST SESSION

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UNQUALIFIED DOCTORS PERFORMING COSMETIC SURGERY: POLICIES AND ENFORCEMENT ACTIVITIES OF THE FEDERAL TRADE COMMISSION—PART I

TUESDAY, APRIL 4, 1989

House of Representatives,
Subcommittee on Regulation,
Business Opportunities and Energy,
Committee on Small Business,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:13 a.m., in room 2359-A, Rayburn House Office Building, Hon. Ron Wyden (chairman of the subcommittee) presiding.

Chairman Wyden. The Subcommittee on Regulation will come to order. Today the subcommittee begins its first in a series of hearings regarding the health hazards posed by a dangerously underregulated medical field, cosmetic surgery. This is a relatively new area of small business opportunity undergoing explosive growth in this country.

Untold numbers of patients seeking the fountain of youth through a facelift, a tummy tuck or an acid peel sometimes get more than they bargain for, suffering infection, stroke, and occasionally death following procedures that are advertised as safe, easy, and painless. According to the American Society of Plastic and Reconstructive Surgery, 11 deaths have resulted from one procedure alone, liposuction, since 1982.

So today the subcommittee will look at the sunrise profit centers of the medical profession, brand-new revenue avenues that are well traveled by both good surgeons and bad. But the evidence shows that too many cosmetic surgeons have no formal surgical training. Others using the shield of established professional society logos have little more training in specific cosmetic surgery procedures.

Some of these pseudosurgeons have realized huge profits in recent years thanks to a laissez-faire Federal Trade Commission. The agency became an unwitting accomplice to the physical and emotional scarring of too many patients by failing to protect Americans from misleading advertising and cosmetic surgery hype.

The subcommittee has reviewed hundreds of cosmetic surgery ads, and here are just a few examples that are particularly relevant. "Hi, I'm Carol. If you'd like to know how cosmetic surgery changed my life, call me." The ad pictures a voluptuous woman in a swimming suit. There are no disclaimers regarding the risks of anesthesia or the dangers of specific surgical procedures. Nor is there anything about the qualifications of Carol's doctor nor even his name.

Or the ad that features swimsuit-clad magazine centerfold Rebecca Ferratti lounging on a sportscar and saying, "So next time you see me draped seductively over a Ferrari you'll know that the true caption ought to read 'Body by Smithdeal.' " Smithdeal is her cosmetic surgeon, not her mechanic.

Or how about "Improve on mother nature. Feel good about yourself. In most cases, surgery is performed on a same day basis." Then there is, "Easy come, Easy go. Body contouring through liposuction and laser surgery." The message is very consistent. "It is easy. It is safe. And it is painless."

Once the province of the rich and famous, elective cosmetic surgery has moved from the plush salons of Southern California to Main Street, USA. Riding a promotional wave of unbridled, often misleading, and sometimes false advertising, the masters of the miracle make-over prey on the insecurities of Americans of all ages.

This is already a multibillion dollar a year business, and it is growing larger every day, and why not? Consider the most popular procedure, liposuction, the surgical removal of fat by a machine not unlike a vacuum cleaner. A cosmetic surgeon can buy $4,000 worth of equipment on Monday morning, do two procedures on Monday afternoon, and then make money all day Tuesday.

The Chair believes that while some cosmetic surgeons have great skills, too many are hucksters who misrepresent their inadequate training to make a fast buck. Based on the subcommittee's efforts, including the review of thousands of documents and interviews with hundreds of doctors, patients, and regulators, the Chair concludes the following:

In most States, drivers have to prove they have liability coverage. But in medicine, doctors can practice cosmetic surgery without any insurance coverage at all and many do.

In every State, any medical school graduate with a State license can perform cosmetic surgery. There are no barriers to entry, public or professional.

Across this country, self-declared medical boards compete for patient dollars with older American Medical Association sanctioned societies. Who is best, who is competent? The public does not know and they cannot find out.

Traditional peer review of cosmetic surgery is virtually nonexistent, since an estimated 95 percent of these procedures are done in doctors' offices outside of hospitals and the protective eye of surgical review boards.

Coast to coast, these office practices are touted as institutes, or centers, or clinics of cosmetic surgery in the most expansive ads. But in too many cases, we see one doctor in a Spartan surgical setting with a skeleton crew. Too often they lack the most basic life-support systems found in the smallest hospital emergency rooms. Neither are we sure that personnel with even the most rudimentary technical training are assisting in these important procedures.

Even normal Government and private audit systems are absent, since in most instances these surgeries are covered neither by Medicare nor private health insurance.

The Federal Trade Commission had a chance to solve some of these problems in 1976. They began a far-reaching and expensive investigation into the cosmetic surgery field. The FTC decided that it was time to force competition upon the medical marketplace. They said that prices would go down and quality of care would not suffer too much. In effect, the Federal Trade Commission's decision gave the green light to claim anything advertising and has short-changed patient safety.

The FTC has dropped the ball, and its decision has ill-served both patients and physicians in this country. Patients cannot tell who is qualified and who is not. The doctors have told this subcommittee that they are frustrated in their efforts to weed out the quacks.

When the subcommittee asked the FTC 2 months ago why it had abandoned its inquiry into cosmetic surgery, FTC Secretary Donald S. Clark replied in a February 16 letter that "We cannot speculate." I do not know what that means. It may mean that they do not know or it may mean that they will not tell us. We hope that FTC Chairman Daniel Oliver can shed light on this perplexing issue at our second hearing on May 2.

Two weeks ago, Food and Drug Administration Commissioner Frank Young told this subcommittee that medical fraud in the United States costs us as much as $40 billion per year. Obviously, false advertising plays no small part in spreading this kind of snake oil.

We have many doctors representing many different specialties prepared to give testimony today. But before they begin, I would like to bring forward two consumers, women who have both had cosmetic surgery, to tell us a few truths about the business that they have learned about the hard way.

[Mr. Wyden's statement and staff position memorandun may be found in the appendix.]

Chairman Wyden. But before I bring our witnesses forward, I want to recognize our colleagues, particularly the gentleman who joins the subcommittee, Mr. Hancock. We are very pleased to have you with us, and we welcome any remarks that you would care to make.

Mr. Hancock. Thank you very much, Mr. Chairman. The matter before us today is no doubt emotional. I understand that there is quite a turf war going on in the medical community within the area of cosmetic surgery. As a small businessman and not a doctor, my personal opinion on this matter is that it should be resolved from within by medical professionals.

I see our interest in this area as to ensure that reasonable competition exists, and let me define the term reasonable competition. By reasonable I mean that the highest level of safety should be guaranteed to those seeking medical services. By competition I mean the medical consumer should be given the utmost choice among providers of such services. So I am looking forward to today's hearings and I hope that the various organizations testifying today will address the points that I have raised.

There are a couple of items that I would like to mention, Mr. Chairman. Because of the time factor that we have, Congressman Bloomfield, the ranking minority member, and I would request that you allow our counsel, Paul Russinoff, to ask prepared questions in the event of our absence later on in the hearing. Also, I would request that the record be held open for 10 days following this hearing for additional comments and remarks.

Chairman WYDEN. I think that the gentleman's requests are extremely reasonable. We welcome today as in all instances participation of you and Mr. Bloomfield. We will recognize minority counsel as he seeks to be recognized today. We will also hold the record open for that 10-day period. I thank the gentleman for his requests which I think are very appropriate.

Mr. HANCOCK. Thank you.

Chairman WYDEN. The gentleman from Virginia, Mr. Sisisky, is the Chair of one of our sister subcommittees on small business, the Subcommittee on Exports. We welcome his participation as well.

Mr. SISISKY. Thank you, Mr. Chairman. I want to commend you for holding these very important hearings. I applaud your diligence and energy in bringing public attention to the whole issue of cosmetic surgery standards. I also want to thank the staff of the subcommittee. I know that they have put in long hours and a great deal of work to pull this hearing together, and they have done a fine job.

The thing that is most disturbing about the whole topic of cosmetic surgery standards and advertising practices and the thing that is most troublesome is that the public just does not know which doctors out there doing this type of surgery, have even minimal training and qualifications. Doctors can have a lot of diplomas and certificates on their waiting room walls, and they can list all kinds of medical societies and organizations after their names, but the public just does not know which doctors are trained and competent in this field.

The local auto mechanic working at the corner garage may have to have more training in his field to get a State license than some of these cosmetic surgeons need to start rearranging a person's appearance. I think that the important thing today is that something positive can come out of this hearing and that is increased public awareness of the lack of even basic peer review that occurs in the field of cosmetic surgery.

The public needs to start asking some tough questions about qualifications. The public also needs better information about the types of surgery that are appropriate for their medical needs and who is qualified to perform that surgery. Until more reliable information is available, the public cannot even begin asking the right questions. Also the cosmetic and plastic surgery profession itself must, and act swiftly to bring some uniformity and some basic standards to plastic and cosmetic surgery requirements and specialization designations.

Mr. Chairman, I again congratulate you on these hearings. I think that there is much work still to be done before the public can begin to even ask the right questions of a cosmetic or plastic surgeon. However, I think you have made a great start by asking some tough questions about the issues to be addressed today.

Chairman **Wyden**. I want to thank the gentleman from Virginia as well, particularly for his kind comments about the staff work, because I think that the staff did a tremendous job in putting this inquiry together. I want to tell him that I look forward to working with him on this and a wide variety of matters that we are going to be dealing with this session.

Our first panel is Ms. Angela Brown of Bowie, MD and Ms. Joyce Palso of Santa Ana, CA. If both of our witnesses will come forward, we will explain the protocol of the committee. We welcome both of you. Ms. Brown and Ms. Palso, it has been the practice of this subcommittee to swear all witnesses.

Do either of you have any objection to being sworn as a witness today?

Ms. **Brown**. None whatsoever.

Ms. **Palso**. No.

Chairman **Wyden**. Please rise and raise your right hand.

[Whereupon, the witnesses were duly sworn.]

Chairman **Wyden**. We are going to make your prepared remarks a part of the hearing record in their entirety. If you could perhaps summarize your principal concerns, I think it would be very helpful. We have a great many witnesses today, and it is going to be a very long hearing. So we will make your prepared remarks a part of the record in their entirety. Why do we not begin with you, Ms. Brown.

TESTIMONY OF ANGELA R. BROWN, BOWIE, MD

Ms. **Brown**. My name is Angela Brown, and I am executive director of Richard's House, a home for throw-away children. I want to take time to express my gratitude that the committee is trying to educate the public about the seriousness of liposurgery.

I underwent liposurgery without any means of antibiotics. I was never told that there was a chance of infection, and it was never conveyed to me that I could hemorrhage. Due to the surgery that I underwent on the morning of May 13, 1987, 3 weeks after the operation the front of my right leg caved in. There was an area of 6 inches long and 6 inches wide which I could place my hand into which I could feel hard muscles and various bones in my leg.

I then went back to see the doctor who conveyed to me that he had taken out too much fat, but do not worry, just rub it and you will be fine. I continued this for several weeks, and I still got the same answer every time I returned, just continue rubbing your leg and you will be fine.

After about 8 months, I finally decided to go and get a second opinion, because my leg was not going anywhere, it was still staying the same. The knee was three times its natural size. I could not bend, I could not run, I could not ride my bike. I have not been able to wear shorts or a bathing suit, and this is my third year.

I went to one doctor who told me the same thing, that you have undergone liposuctioning and there was too much fat removed, and I cannot promise you that I can repair your leg, but I can offer you a 50 percent chance of doing this, but it may require two to three operations. Then he tells me that he himself had done the very same thing to a previous patient. He was doing surgery and he had done the same thing to a woman. Had it not been for a doctor standing right by who was a more learned person in liposuction surgery, her leg would have been exactly like mine. Then I went on to ask him how many liposurgeries he had done, and he said just a few. So after hearing that remark, I definitely did not choose to use him.

I then went to another doctor for an evaluation. His words were the same, too much fat has been removed from your leg, you have hard tissue and possibly nerve damage, I would suggest at least three operations. His fees pertaining to three operations and hospital costs were going to run me $25,000 to correct my leg. Needless to say, I did not have that kind of money, so I did not do that.

But one important thing that I would like to stress today is on this particular doctor's walls he had a cartoon that said, "Treat yourself to a tummy tuck on your VISA card and a buttock lift on your MASTERCARD," which you know was representing to me that if you do not have cash then we take plastic cards, get your business with the credit cards.

So then I heard or saw an advertisement on TV representing the Cosmetic Surgery Center. I wrote the number down, but I took time before I decided to call this place. After that in about a couple of weeks I called the place, and was told by the receptionist that they had two kinds of doctors. One doctor worked from the waist down, and another doctor worked from the waist up. Whichever problem area that you had, that is the doctor they would recommend you to.

So they gave a telephone number and I called it, and I was referred to Dr. Antonio Mangubat at the Cosmetic Surgery Center. I visited him in March 1988 and he looked at my leg and told me definitely that there had been too much fat removed from my thigh and that I would require fat grafting, which means that almost every visible part of the body where there was fat that they would have to suck that out, cleanse it through like a strainer, and then insert it with a large hypodermic needle back down into my thigh.

So I waited 6 months fearing because I was just afraid to go through the surgery again. So finally on August 11, 7½ months ago, I underwent corrective surgery. I would like to tell everyone in this room that it was very, very painful. Up the front of my thigh, if anyone exercises they know that is the quad area, and my quads were 18 inches. After my fat grafts, the upper part of my leg was 42 inches.

The pain is something that I cannot express, it was like a hot poker on your skin, and your leg would just throb and throb. Plus there was fat taken from the abdomen. The left leg—the previous doctor who had done the surgery, unknown to me my left leg was 3 inches larger than the right leg. I still have a cavity up on the back of my right leg which is going to have to be filled in. If I raise my leg, I feel bone.

I even have to had fat from behind my arms to get enough of quantity of fat to fill in the leg. Because when you are injected with fat grafts, you lose 50 percent of those cells, they die. You do not even know after going through the surgery for 3 weeks if these fat grafts took.

So as it stands right now, to sum it up, I have a little cavity and I have an area of fat which is about the size of a double grade-A large egg which is still hanging over on the right thigh. Dr. Mangubat has expressed to me to wait until my first anniversary which will be this August 11, and he is going to try to see what he can do. He has tried to inject it with a hypodermic to see if he can draw maybe fluid out of the leg, but nothing came out of it. So that is basically where I am right now.

[Ms. Brown's statement may be found in the appendix.]

Chairman **Wyden**. Ms. Brown, thank you. Thank you for your willingness to speak out as well. I will have some questions in a moment. But I want you to know that we very much appreciate you being here and your courage.

Ms. **Brown**. I am grateful to be here, because I do not want to see somebody else get butchered. Because the man that I had was board-certified and highly recommended. I go to sleep and I wake up like this.

Chairman **Wyden**. I thank you very much for coming. We will have some questions in such a moment.

Ms. **Brown**. Thank you.

Chairman **Wyden**. Ms. Palso, we welcome you.

TESTIMONY OF JOYCE PALSO, SANTA ANA, CA

Ms. **Palso**. Congressman Wyden, thank you very much for allowing me to be here today. Five years ago, I never dreamed of ever appearing before a congressional subcommittee hearing. However, 5 years ago, I was not thinking too much about plastic surgery either. Then I began to see many, many advertisements like the ones that you see over here, and thought well, gee, with all of this advertising this cannot be too unsafe.

Four and a half years ago, I had a tummy tuck. That requires an incision from hip bone to hip bone, over a 12-inch long incision. The doctor that I chose after checking him out with the American Medical Association and the California Department of Health did the operation in his office. When I went to him for a consultation, I said that I did not know that you could do this in an office, I thought this had to be done in a hospital. He said why would you want to go through that expense. I said what about the safeness of it. He said it is just as safe in my office.

Four weeks after the surgery, I still had an open wound, and I had uncontrolled infections, three kinds of infections. Staph was one, pseudomonas was another, and another. The infections spread through my bloodstream to my lungs and landed on the mitral valve of my heart. The mitral valve in my heart was destroyed by the infection. I ended up in an emergency room in a hospital—very, very close to death.

I was told by a cardiologist that the only way to save my life would be to have open heart surgery to implant an artificial valve in my heart. But they could not do this as long as there was infection in my body. I was in emergency for 7 hours, and in and out of the hospital six times for a year and a half. Five times I went into heart failure.

It was difficult to get the infections under control. I guess, going back, that one of the most amazing things about all of this was that I thought that cosmetic surgery was safe. Why would anyone, the AMA or anyone else in the medical profession allow these so-called physicians—whom I now know are a group of men who can take a weekend course—and decide that they can do this? I found out the hard way that the risks are very real. I hate to think that this could happen to anyone else.

Just before I decided to have cosmetic surgery, I was very happy and very healthy and had a successful business. I felt generally good about the middle-aged woman that I had become, but I also felt that I could look younger. I knew quite a few people who had had at least one cosmetic surgery procedure. Again, ads like these that you see over here were everywhere. I was not sure that I knew how to choose a good doctor. I had been advised to find one who was board-certified. I did not know the difference in the boards then, but I do now.

I found a doctor that advertised as a cosmetic surgeon who did a wide variety of procedures, several of which interested me. Just to be sure, I asked for his list of credentials, and I checked on these credentials by calling AMA in Chicago. They told me that he was a member in good standing. I know now that all that meant was that he had paid his dues. I called the California Board of Quality Assurance, and they told me that they had nothing on him. Now I know that he had 11 lawsuits against him at that time, and that the State had been trying to revoke his license 2 years before I went to him, but they did not tell me that.

He advertised as being board-certified by the American Board of Cosmetic Surgery. I know now that you cannot tell a good board from a bad one, and that such titles can be meaningless. Anyway I chose him, because after calling these different agencies, I felt comfortable with that.

He performed a tummy tuck on me in his office. What happened after that, as I have told you, has been a nightmare. My doctor made one mistake after another. When I told him that I was short of breath and dizzy all of the time, he just told me not to worry and that it was just the aftermath of surgery.

When my infections went away sufficiently to allow my new doctors to do surgery without the risk of dying on the operating table, they found 1 foot of suture that the doctor had left inside of me, and the infection was clinging to this 1 foot of suture. That was why it was making it difficult for the infection to get under control.

I also know that the doctor should have been giving me intravenous injections of antibiotics. He was giving me oral antibiotics, which later an infectious disease specialist told me would not touch the infections that I had.

I finally began to get my life back together. I am rebuilding my business, and I am trying to put all of this behind me. But then when things like this happen today, it brings it all back to me. I resent the fact that it took the State of California 4 years to take this doctor's license away. I am afraid to think how many other people he may have hurt or even killed in the meantime.

I know that the medical profession is a powerful one. Today I know the difference between a member of the Board of Plastic and Reconstructive Surgery and a member of the Board of Cosmetic Surgery. I did not know the difference then when I chose the doctor to do my tummy tuck. If I had known, I would not have chosen him.

I found out too late that my doctor did not learn to do tummy tucks in any medical school or in any residency program. What training he did seemed to come from a weekend course here and there. It does not look like he ever really learned anything.

If there is a group of doctors who choose to form a so-called board, should it not be their responsibility to make sure that their members are really qualified, that patients have at least a reasonable expectation that these surgeries can be done safely? Is it ethical for doctors to form a teaching academy and then take no responsibility for the incompetent doctors that they create on a weekend or two?

Should not the American Medical Association do more to protect patients from unqualified and even unscrupulous doctors? Should not the State Medical Associations have more control over what their members do to the public.

One thing that I did not say is that after this doctor operated on me, 2 months later he did the same procedure on a 36-year-old registered nurse. I am the lucky one because I am alive today and she is not. She died.

Finally, should not the Government at the very least stop doctors' ads that lull us all into a false sense of security? Should not ads that make us believe that we can have cosmetic surgery done safely and well with no risk be stopped? Cannot it go back to when it was unethical for physicians to advertise?

Whose job is it? Should the Federal Trade Commission be responsible? Should the Food and Drug Administration be responsible? All I know that is someone in the Government should be doing their job. Someone should be in control. I do not believe that anyone is in control at this time. Thank you for listening to my story.

[Ms. Palso's statement may be found in the appendix.]

Chairman WYDEN. Ms. Palso, thank you as well for coming to this subcommittee. I know that for both you and Ms. Brown that this is not an easy matter to come and discuss these operations and your own situation. I wanted you to come because we felt that it would be that much easier to push some of the reforms that you and others have advocated, and we thank you. Let me ask just a few questions of each of you, and then I want to recognize my colleagues.

Ms. Palso, to begin with you, it seems to me that you went to Herculean lengths in order to try to inform yourself about how to find a good doctor. You did everything almost by the book at least in the limited way that we now know. Yet you nearly died, in your own words, as a result of your experience.

Did you think at the time that you began all of this that cosmetic surgery really was not all that dangerous, based on what the physicians were telling you?

Ms. **Palso**. Yes; when I went for the consultations, and I am repeating myself, but I asked, how can this be safe in an office? He said, just as safe as anywhere else. Again I thought that someone had control. If no one in the medical profession were in control, why were they allowing ads like these?

Of course, the ads do not show the botched jobs. I am in the advertising business myself, and I know the power of advertising. I did not think that it could be dangerous. A lot of people were having it done. I did not know that nobody had any control over these people.

Chairman **Wyden**. What kind of training did your physician have to do a tummy tuck specifically?

Ms. **Palso**. I really do not know if he had any. He gave me, at my request, a list of credentials that was quite impressive. Some of these guys are pretty clever. They form boards, and they go to the printer and they have their little certificates made up and hang them on their wall, and these are all impressive. Specifically about any tummy tuck training, I do not know if he had any.

Chairman **Wyden**. You said that you are in advertising, that you are in the profession.

Would you say that the advertising of cosmetic surgery is extreme by reasonable advertising standards in this country?

Ms. **Palso**. Very extreme.

Chairman **Wyden**. I think that my colleagues are going to have some additional questions for you. But again I want to thank you for your helpful testimony, Ms. Palso.

Now with respect to you, Ms. Brown, your first doctor was a plastic surgeon, is that correct?

Ms. **Brown**. He was a plastic and a reconstructive surgeon. I failed to mention because I did go through my notes rather hurriedly that he was supposed to be the best. He was a reconstructive surgeon, he did cancer patients, and he replaced noses and jaws, and he replaced breasts from women who had undergone mastectomies. After my interview with him, he told me that I was a prime candidate for liposurgery.

Chairman **Wyden**. Did he tell you with any degree of specificity about the risks or about the possible complications?

Ms. **Brown**. No; he said that I would have no risk because I was tall, slender, and very firm with good muscles from working out. That with the small areas that I had that it would be a piece of cake.

Chairman **Wyden**. Now, many doctors are concerned about the potential for infection with liposuction. Did your first doctor give you any medication?

Ms. **Brown**. No; he did not.

Chairman **Wyden**. No antibiotics?

Ms. **Brown**. No.

Chairman **Wyden**. No medications at all?

Ms. **Brown**. I had a prescription for some Tylox for pain. That was the only thing that I was given.

Chairman **Wyden**. How many times did you go back to see your original doctor before you sought out a second, third, and finally fourth opinion?

Ms. **Brown**. I continued seeing him for a period of about 5 months. When I tried to call him back to correct my leg, he had already been arrested.

Chairman **Wyden**. Did he ever tell you that his mistake of taking out too much fat could not correct itself?

Ms. **Brown**. No; he told me that it could correct itself, for me not to worry, that everything would turn out fine. Just rub my leg, and I would be fine.

Chairman **Wyden**. What exactly did the physician tell you about his qualifications to do your surgery?

Ms. **Brown**. When I first went to him, I went through doctor's referral and this man was board-certified. I asked him, my first concern was had he done liposuction surgery, and he said yes. But he said that I am flying to Los Angeles in April, so let us wait until I return to see if there are any new procedures that are being done before I decide to do it along your thighs.

So I thought that he was showing a little bit of care, that he was going to go away at least and then come back and tell me what to do. So after he returned, he made my appointment. I went in that morning, and I was just told to get undressed. I only had three photographs taken, a standing view, a side view, and a back view. Then I was told to put my own self on the operating table. He did not even take the pictures in fact, because he asked his nurse to take the pictures because he had difficulty taking pictures.

But I want everyone in this room to realize that I did not just jump into liposurgery. I had been exercising for 16 years every day. So I gave it a lot of thought. If I had it do over again, I do not think that I would ever go through that. For a little bit of fat, I ended up with a nightmare. Because when I awoke, I have not been the same person.

Chairman **Wyden**. Did you ask your current doctor, I believe that it is Dr. Mangubat, if he was board-certified by anyone?

Ms. **Brown**. Yes; I did ask him if he was board-certified. When he said no, I was a little apprehensive. But I had asked him how many of these liposuction surgeries had he done and he said hundreds. With the rapport that he showed me, he showed concern, and I felt more comfortable in that atmosphere than I did walking into the other surgeon's office who was board certified.

I was at the point where I was so dismayed, you know, not being able to wear shorts. I have not been able to go to the beach for over 2 years. There were many days when I thought of going out and sitting in my car and saying good-bye world. No one realizes the traumatic feelings that you get. Because cosmetic surgery is elective surgery, we choose that surgery ourself. So if there are complications, we have not only the doctors to blame but ourselves because we chose to do it. It is vanity, it really is. You have to weigh one side against the other. I wished that I had left those little pockets of fat.

Chairman **Wyden**. One last question if I might, that physician Dr. Mangubat, did he tell you that fat injection procedures like the one that he gave you can and do fail?

Ms. **Brown**. Yes; he told me that I would require twice the amount of fat into the area, and that it is iffy if it takes, and that is why he was going to inject so much and that he was willing to work with me. I just felt that I did not have anything to lose. I mean I was ready to sink to rock bottom. I could not do anything. I mean last summer was our hottest summer, and I went to work in gym and sweat clothes. This is the first time that I have worn a skirt in 2½ years, almost 2 years, excuse me, it will be 2 years next month.

I could not cross my legs. I could not put my left leg across my right leg, because the pain would go up to my hip. I could not bend my leg.

Chairman **Wyden**. I want to recognize my colleagues at this point. Again I want to thank you for your willingness to speak out. I am very much committed to seeing reforms in this area. I think that at the very least that the Federal Trade Commission has got to arouse itself from its regulatory slumber, because I think that the evidence is very clear that there is an awful lot of hype and misleading advertising going on. At the very least, they ought to step in and do the job that they are charged with, which is dealing with deceptive and misleading advertising. So I want to commend you.

Let me have my colleagues ask some questions, because I know that they have strong views on this. I want to recognize my friend from Missouri at this time.

Mr. **Hancock**. Thank you very much.

You mentioned when the chairman, Congressman Wyden, was questioning you, that the doctor had been arrested, and I did not find any place in the testimony about an arrest.

Was this the first surgeon, the surgeon that performed the original surgery?

Ms. **Brown**. The original surgery that was performed on May 13, 1987, shortly after that he was arrested.

Mr. **Hancock**. Could you tell me why he was arrested?

Ms. **Brown**. Drugs.

Mr. **Hancock**. It had nothing to do with his professional practice or anything or did it?

Ms. **Brown**. I cannot really answer that question honestly, because I did not know that much of his life.

Mr. **Hancock**. Is he still practicing?

Ms. **Brown**. No; his license was revoked.

Mr. **Hancock**. How long was this after the surgery that you had?

Ms. **Brown**. I would say that about 8 months after the surgery that his license was revoked and he was incarcerated.

Mr. **Hancock**. Thank you.

Ms. Palso, you mentioned that you had been in business, are you still in business?

Ms. **Palso**. I lost all of my business during the time that I was ill, and I am now getting that business back in order, trying to rebuild the business.

Mr. **Hancock**. What type of business were you in?

Ms. **Palso**. Advertising.

Mr. **Hancock**. Advertising, so you are familiar with this type of thing then.

Ms. **Palso**. Yes.

Mr. **Hancock**. Thank you very much. Thank you, Mr. Chairman.

Chairman **Wyden**. I thank the gentleman.

The gentleman from Virginia.

Mr. **Sisisky**. Thank you, Mr. Chairman. I am a little bit confused. Ms. Brown, you went to a board-certified——

Ms. **Brown**. Plastic and reconstructive surgeon.

Mr. **Sisisky**. You, Ms. Palso, did not, is that correct?

Ms. **Palso**. I went to a member of the Board of Cosmetic Surgeons.

Mr. **Sisisky**. So, Ms. Brown, you basically did everything you are supposed to do?

Ms. **Brown**. Right.

Mr. **Sisisky**. Of course with any surgical or medical procedure, there is risk. I think we all recognize that.

Ms. **Brown**. Yes; that is true.

Mr. **Sisisky**. Now, and this is where my problem comes in, do either of you have a family physician, and did you ask your family physician what they recommend?

Ms. **Brown**. No; I did not ask.

Mr. **Sisisky**. I am not trying to put words in your mouth, but did you not ask your family physician because as a result of seeing these ads you thought your surgery would be an easy procedure? Is this what happened? Because, I am not really sure what happened in your cases.

Ms. **Brown**. Let me try to sum up what happened to me. Like I said, I was slender and I had some fat pockets, and I belonged to a gym. Women would come in there, and one day they have large abdomens and 2 weeks later you see them completely flat. After awhile the word starts buzzing, liposurgery is great, the end of fat city. Walk in heavy and walk out thin. So it was intriguing.

I thought, well, here are all of these years, 16 years that I have worked out, and I have dieted and I am a health fanatic, why don't these pockets go away? I thought, this will be great. The doctor said 30 to 45 minutes and that I would not feel bad at all, that I was a great candidate. So it was the lure that really got me in there.

Mr. **Sisisky**. Did you have anesthesia?

Ms. **Palso**. Yes: I did.

Mr. **Sisisky**. Did they have a certified anesthesiologist there?

Ms. **Brown**. Yes; they did do that.

Mr. **Sisisky**. They did do that.

Ms. **Brown**. Yes.

Mr. **Sisisky**. Are you in litigation with this physician?

Ms. **Brown**. I am trying desperately, yes.

Mr. **Sisisky**. How about you, Ms. Palso?

Ms. **Palso**. I settled last October. It took 4 years. I settled out of court.

Mr. **Sisisky**. Did he have malpractice insurance?

Ms. **Palso**. Yes; he did.

Mr. **Sisisky**. How about you?

Ms. **Brown**. They conveyed to me that at the time that this surgeon who did my surgery on May 13, 1987, that he did have malpractice until January 1, 1988. So he was covered.

Mr. **Sisisky**. So basically, you had the procedure because of word of mouth?

Ms. Brown. No; I also talked to other patients that he had done, and not one had anything to say bad about it. They said that it was great, that they felt fine, that they had not received any complications.

Mr. Sisisky. Did he give you the names of those patients, or you found them?

Ms. Brown. They came up to me in a gym. A group of women working out, they do talk. But there is one very important thing. With elective surgery, a lot of women are not going to come up to you and say I had a nose job, I had a tummy tuck. They do not want that to be known, because that is personal and they do not want to talk about it.

Mr. Sisisky. I have some strong feelings about these issues and particularly the advertising. But what I am really trying to find out is: what can the Federal Government do? In your case, Ms. Brown, there really nothing was that the Federal Government could do was there? Here was a board-certified physician who made an error.

Ms. Brown. Right.

Mr. Sisisky. Mr. Chairman, I am trying to really find out what these witnesses think the Government could have done. The U.S. Government can do a lot of things, but what do you, Ms. Brown or Ms. Palso think that the Government ought to do to protect you, the consumer?

Ms. Brown. I can express one thing and I do not expect everyone here to go along with it. But I know that when we are a new patient and we go to a doctor's office, that we are asked to fill out a form—name, address, Social Security, home phone, work phone, the medications that we have been on, have we ever been on drugs, do we do street drugs, are we allergic to anything. Basically, the doctor knows everything about us, but we know absolutely nothing about the doctor.

We are not patients, we are victims. How can we get something from the doctor stating my name is so and so, and I live in such and such a place, I do not do drugs. But who is going to do that. Nobody is going to do that.

Mr. Sisisky. But you did know something about this doctor?

Ms. Brown. A little bit, but I mean he knew more about me.

Mr. Sisisky. I am being the devil's advocate, Mr. Chairman.

Ms. Brown. This was a painful thing, believe me. I would not wish this surgery on my worse enemy. Because number one, I felt bad because I chose to do it, and number two, I look terrible.

Mr. Sisisky. Ms. Palso, what do you think the Federal Government should do?

Ms. Palso. Someone has to have some control, someone. Right now, it looks as though no one has any control. When I called AMA, why could they not have told me that—stay away from this guy? He had paid his dues, so that meant that he was OK.

Mr. Sisisky. You called AMA?

Ms. Palso. I called AMA in Chicago to check on him. I did ask for his list of credentials, and he had everything in the world on there, which meant, I think, nothing. I called California State in Sacramento. When the State investigators came to investigate me, they had never had a case where anyone had investigated anyone as thoroughly as I had investigated this guy. Yet it still happened.

I asked to speak with some patients that he had done procedures on. He would not give me their phone numbers, but he had them call me. I am not sure, but I think that two of the three were decoys. I could not tell by looking at them that anything had ever been done.

What the Government can do, I do not know. I know that it is going to be a difficult task. I thought that it may be easy. But after listening to this lady, I do not know. Because I thought that just anybody who is not a member of the Board of Plastic and Reconstructive Surgery, not to let anybody else do that. At least they have had we know general surgery training and plastic surgery in order to become a member of that board.

The other guys out there, maybe they are GP's, and that is what this guy happened to be whom I went to. Maybe they are ear, nose, and throat people who do some work on the nose, but all of a sudden they are doing tummy tucks too. So it seemed to me that it would be easy. But now after listening to this lady, I guess it is not so easy.

Mr. **Sisisky**. I thought so too, then when I heard Ms. Brown's testimony, I got a little confused. Thank you very much.

Chairman **Wyden**. Let me ask just a couple of other questions. In your two instances, what was the status with respect to malpractice insurance and your physician? Ms. Palso, I understand that it is your view that your doctor had malpractice insurance during part of the time, but not during all of the time. What was the status?

Ms. **Palso**. When I first went to file suit against the physician, I was told by the attorney that he did not have medical malpractice insurance. I said well, what does that mean, does that mean we cannot get rid of this guy, are you going to let this guy continue to cut on people? That particular attorney would not take the case, because he thought that he no medical malpractice insurance.

I went to another attorney and I said somebody has to do something to these people. So he took the case, and found out that just before he operated on me that he did not have medical malpractice insurance, and just after he did not, but while I was his patient he did.

The State of California has a cap of $250,000 for any medical malpractice case no matter how severe the case. I went through 4 years of fighting. It takes 4½ to 5 years to get a trial date in the State of California. That is also why it took so long to take his license away, because he had not been proven guilty. None of the lawsuits, none of the 11 lawsuits that he had against him when I went to him, had gone to trial, so he had not been proven guilty.

His license was revoked after 4 years. The State had started 2 years before I went to him, and it took 2 years after. His license was revoked for incompetence, neglect, and frauding insurance companies.

Chairman **Wyden**. Ms. Brown, I gather that your experience on the legal front is not all that different.

You went to one lawyer and he could not find insurance initially, could he?

Ms. Brown. From what he conveys to me, he does not know if Dr. So-and-So had malpractice insurance, and he says, how can I find out? And I said, that is what I am paying you for, and he says, I cannot put a gun to the doctor's head and make him tell me. So right now, I am in a state of limbo. I still owe money to Dr. Mangubat for his corrective surgery which I have not paid him.

Chairman **Wyden.** My colleague from Virginia, Mr. Sisisky, makes a very important point with respect to when we see the problems where do we go. It is clear to me that the Federal Trade Commission can do something about advertising. Ms. Palso, it is good to know that someone like yourself who is a professional in the advertising world sees these as extreme. Because by any standards, this is advertising that is way out of bounds, and just far beyond what reasonable advertising should constitute. So that is one thing.

But there are other things, and certainly there are initiatives that can be pursued outside of the Federal Government. One that seems clear to me is, we have to take additional steps to strengthen quality assurance in this area, so that consumers have a reasonable expectation of receiving decent quality care. Now my initial feeling is that that can be done at the State level, that that is not something that the Federal Government can take on. But that will certainly be an additional area that we will pursue.

Finally, it seems to me that the voluntary societies can take additional steps to try to weed out those in their ranks who are not up to professional standards. I believe that we are going to hear testimony today from several of the professional societies saying that it is long overdue that such additional steps be taken by the professional societies on a voluntary basis. So there will be a number of areas that we will be pursuing in our inquiry. I just want to thank you both again.

Ms. Brown. May I just say one more thing?

Chairman **Wyden.** Sure.

Ms. Brown. When my doctor was incarcerated, I was given a phone number where I could reach him, because I called him and I told him that my leg was seriously injured and that I wanted to have it corrected, and he said what are you calling me for, I do not give a hoot about your leg. There was no concern and there was no feeling that he had done this to me.

Chairman **Wyden.** I must say, as I did originally, that I think that there are many concerned and very skilled practitioners in this field, but there are just too many who seem to be putting the quick dollar first and patient welfare second.

Ms. Brown. But how do you know when a doctor is qualified if that doctor is on drugs and he is going to operate on you? We have no way of knowing that.

Chairman **Wyden.** Ms. Palso, with respect to your own situation, what did advertising contribute to your decision to actually have the surgery? Was it a major factor in your having the surgery?

Ms. Palso. Actually not that much. Just the fact that advertising was out there again, and I have said this before, I did not realize that no one had any control over the advertising. It is not like they are selling a tube of toothpaste. These are very enticing. We would all like to look like some of these people. Actually it did not have that much to do with my decision. Probably seeing friends of mine who had had procedures—that probably had a stronger bearing than the advertising for me. Today now in California, there are even tops of buildings with the names of these cosmetic care places.

Chairman **Wyden**. Thereby giving one the impression that it is an accepted kind of service and that it is safe and painless.

Ms. **Palso**. Right.

Chairman **Wyden**. Thank you very much, Ms. Palso.

Does the minority have any additional questions that they would like to ask at this time?

[No response.]

Chairman **Wyden**. Unless you have anything that you would like to add, we will excuse you and thank you again for coming.

Ms. **Brown**. I would like to add one thing. Do not let vanity chase you into a plastic surgeon's office. If you cannot work it off, if you cannot diet, then go looking. I cannot give anyone a simple answer how to find a good one, because I thought that I had a good one. Basically we are victims in the hands of the doctors.

Chairman **Wyden**. Thank you both, and we appreciate your cooperation.

Our next panel is the American Society of Plastic and Reconstructive Surgery. Dr. John Jarrett, president-elect, Eugene, OR; Dr. Norman Cole of Louisville, KY; Dr. Mark Gorney, San Francisco, CA; Dr. R. Barrett Noone, Philadelphia, PA; and Dr. Harvey Zarem, Santa Monica, CA.

Gentlemen, we welcome you, and we thank you for your patience. It is the practice of our subcommittee to swear all of the witnesses.

Do any of you have any objection to being sworn today?

[No response.]

Chairman **Wyden**. Please rise and raise your right hands.

[Whereupon, the witnesses were duly sworn.]

Chairman **Wyden**. We will make your prepared remarks a part of our hearing record in their entirety. I am going to have to keep this panel to our committee rules for 5 minutes of oral testimony. We will make your prepared remarks a part of the record in their entirety. But because we have so many witnesses, I am going to have to keep each of you to 5 minutes.

Dr. Jarrett, we are particularly pleased to see an Oregonian with us, and we welcome you and thank you for the fine cooperation that you have shown us. Why do you not begin.

TESTIMONY OF DR. JOHN JARRETT, PRESIDENT-ELECT, AMERICAN SOCIETY OF PLASTIC AND RECONSTRUCTIVE SURGEONS, EUGENE, OR

Dr. **Jarrett**. Thank you. Mr. Chairman, I am Dr. Jarrett, president-elect of the American Society of Plastic and Reconstructive Surgeons. It is a pleasure for us to appear today on behalf of ASPRS. Our written testimony which you have has been submitted as a permanent part of the record. Before I introduce the other members of our panel, I would like to begin with a few advanced comments about some of the observations that may be made this morning.

You may hear today from other organizations about a Federal Trade Commission investigation conducted into alleged restraint of trade by the American Society of Plastic and Reconstructive Surgeons. Let me take this opportunity right now to set the record straight. The FTC did indeed launch such an investigation in the mid-1970's, but it was not limited to ASPRS. It was an industry-wide search for documentation in which a large number of specialties received subpoenas. In the case of ASPRS, a proposed consent decree was submitted to the society for its response. After receiving our reply, the FTC concluded that no further action was warranted and terminated its investigation.

Pertaining to that investigation, you will hear references today to a 14-year-old memorandum prepared in 1975 by the society's former executive director. In fact, you will see pictorial displays of portions of this memorandum. This memorandum was never seen by anyone other than the president of the organization. It was never received or reviewed let alone approved as policy by the society's board of directors.

The FTC in its 1977 investigation reviewed this memorandum and concluded that there was nothing to it and that it only reflected the personal musings of the society's then executive director. It never reflected society policy, and it does not reflect society policy, but it continues to be dragged up only by certain groups because they are reluctant to address the real issue today which is quality.

Furthermore, this issue has no bearing on the deliberations of this committee, which is examining the quality of care delivered to cosmetic surgery patients. Let me say up front that ASPRS has absolutely no argument with the fact that board-certified otolaryngologists who are trained in facial cosmetic surgery are fully qualified to perform facial cosmetic surgery.

You may also hear charges that the ASPRS is engaged in a propaganda campaign to disparage other medical specialties. However, the society has neither directly nor indirectly conducted such activities. On July 5, 1982, our board of directors approved the following statement: "ASPRS does not accept, condone, or encourage statements demeaning or disparaging other physicians or groups of physicians."

ASPRS deplores and disapproves of individuals who appear in media or other forms as self-appointed champions of the specialty. Instead our society has focused its communications on educating the public on the strong qualifications of its members, surely an appropriate activity.

Finally, you may see examples offered of bad surgical results for which some of our members may have been responsible. It is a universal truth that even among the most qualified physicians that a less than satisfactory result can and does occur. However, we believe that the probability of such an outcome is significantly less when the surgeon completes an accredited residency program in plastic surgery and is certified by the American Board of Plastic Surgery.

We also know that some of our members have been guilty of placing deceptive advertising. However, there are bad apples among every group. As I have outlined in my written testimony, our society acts quickly to discipline these individuals through a tough Code of Ethics.

The testimony of our society will begin today with Dr. R. Barrett Noone, director of the American Board of Plastic Surgery, who will speak on the education and certification of a plastic surgeon. He will be followed by Dr. Harvey Zarem, a senior examiner for the board, who will speak on how to select a qualified physician. Dr. Norman Cole, our treasurer, on hospital peer review as a measure of competence, and Dr. Mark Gorney, a past president, will speak on advertising in plastic surgery. I will conclude with a discussion of quality assurance in plastic surgery.

Let me say, Mr. Chairman, that all of our initial directives seem to indicate that we had up to 10 minutes for our presentation, so we will try to compact it if we can. Dr. Noone.

[Dr. Jarrett's statement may be found in the appendix.]

TESTIMONY OF DR. R. BARRETT NOONE, PRESIDENT-ELECT, PLASTIC SURGERY EDUCATIONAL FOUNDATION; DIRECTOR, AMERICAN BOARD OF PLASTIC SURGERY, INC., PHILADELPHIA, PA

Dr. NOONE. Thank you very much. May I have the lights, please, for the video machines, because we have slides to show.

Mr. Chairman, my name is Dr. R. Barrett Noone, and I am president-elect of the Plastic Surgery Educational Foundation, and a director of the American Board of Plastic Surgery. I appreciate the privilege of addressing the subcommittee this morning on the topic of training and certification in plastic surgery. I direct you to the slides of my presentation of the left wall of the auditorium.

Webster's dictionary defines a specialist as a physician who is qualified by advanced training and certification in a specialty examining board to limit his practice to a particular class of patients, or of diseases, or of techniques such as surgery. In plastic surgery, this advanced training is received in an accredited residency program, and certification is granted by a specialty board approved by the American Board of Medical Specialties.

The plastic surgeon places the safety of his patient first when he selects the path of graduate medical education which gives specific specialty training in an accredited residency program. This program is subject to intensive peer review at the completion of which he is examined by an approved specialty board and is then granted certification by this specialty board.

Following the M.D. degree, the training needed to prepare any physician for a practice in any specialty area is received in a residency training program, generally based in a university or other teaching hospital. Accreditation of residency programs is provided by the Accreditation Council for Graduate Medical Education known as the ACGME. This is a private organization which accredits over 6,000 residency programs in 24 major specialty areas. Plastic surgery is one of these 24 major specialty areas. There is no residency program or accredited specialty for cosmetic surgery alone. This area is included in the specialty of plastic surgery.

The member organizations of ACGME include the American Board of Medical Specialties, the American Hospital Association, the American Medical Association, the Association of American Medical Colleges, and the Council of Medical Specialty Societies.

Therefore, Mr. Chairman, you can see that every aspect of organized medical education in the United States is represented through the ACGME to provide continuing review and accreditation of every residency program which is training your specialists.

Specific requirements are established for each specialty. The general requirements for residencies are developed by the ACGME and are applied to all specialty areas. The special requirements for residency programs are developed by the residency review committees in each specialty, and subsequently are approved by the other specialties. Therefore within this structure, an extensive network of peer review from within the specialties and from the other associated specialties in the ACGME guarantees quality of the residency program and the ultimate safety of the patients that are treated by its graduates.

The residency review committee in plastic surgery is the watchdog of plastic surgery training programs. The committee serves to constantly examine the facilities, the resources, the faculty, and the administration of residency programs.

In the early part of this century, there was no system to assure the public that a physician claiming to be a specialist was indeed so qualified. Until the development of the specialty board movement, each physician had been the sole assessor of his or her qualifications to practice a given specialty.

In the early part of the century, specialty societies and medical education institutions encouraged the development of boards to define specialty qualifications and to issue credentials to assure the public of the specialist's qualifications.

The American Board of Plastic Surgery was established 51 years ago to serve such a function in the area of cosmetic surgery. The problems that we are addressing this morning in cosmetic surgery, mainly those of self-designation with limited training and exposure to specialized training programs, is setting the practice of cosmetic surgery back 80 years to the initial founding of specialty certification.

This is appalling and certainly unnecessary since the pathways for training and certification have been well established in plastic surgery since 1938. As the original boards and societies matured, it was only natural that they should coalesce and organize a national system to provide for the recognition of qualified specialists. Therefore the American Board of Medical Specialties or the ABMS was formed.

This body provides information to the public, the Government, the medical profession, and member organizations. It serves as the spokesman for all approved specialty boards. It is composed of 23-member specialty boards, approves the development of new specialty boards, avoids duplication of efforts of the specialty boards, and establishes the standards of operation of the specialty boards.

The American Board of Plastic Surgery is recognized by the ABMS as the board which examines its candidates in the complete spectrum of cosmetic surgery. Other boards recognized by the ABMS may examine on cosmetic surgical procedures related to a special anatomic field only, such as otolaryngology or ophthalmology.

The requirements of the American Board of Plastic Surgery are documented in detail in a 32-page booklet. The American Board of Cosmetic Surgery is not and has never been recognized by the American Board of Medical Specialties. Its requirements are documented in a single paragraph.

Among the policies of the American Board of Plastic Surgery is a statement on advertising in medicine. The board recognizes the role of legitimate advertising in the changing medical scene, but it does not approve of advertising which arouses unrealistic expectations, which is false or misleading, which minimizes the magnitude and possible risks of surgery, or which solicits patients for surgery which they might not otherwise consider. Such advertising is considered improper and inconsistent with the high standards of professional and ethical behavior implied by the American Board of Plastic Surgery.

In order to become certified by the American Board of Plastic Surgery, a physician must complete a specific course of training in a residency program, and then must pass a vigorous examination. The formal training consists of a minimum of 5 years of a residency program following medical school, and many plastic surgeons have 6 to 8 years.

The prerequisite training before training in plastic surgery consists of one of three pathways which may include general surgery or otolaryngology. Following the prerequisite training, a candidate for the American Board of Plastic Surgery must take not less than 2 years of requisite training in plastic surgery.

It is only within the structure of an approved residency training program that a physician can become a surgeon by safely achieving the skills necessary to perform surgery as an independent operator. Candidates for certification by the American Board of Plastic Surgery are required to take examinations. The qualifying examination is taken after residency and consists of a full day written examination. Upon successful completion of the qualifying examination and following at least 2 years of successful practice in plastic surgery, the candidate is eligible to sit for the certifying examination.

The completion of minimum standards of continuing medical education is a requirement of all board-certified plastic surgeons. The requirements for continuing medical education as established by the American Society of Plastic and Reconstructive Surgeons parallel those of the American Medical Association and many State medical societies, and their requirements are listed.

In summary, Mr. Chairman, the education of a plastic surgeon is provided during a lengthy course of study in an approved residency program which is accredited by the ACGME and supervised by the residency review committee. Certification is earned by passing rigorous examinations prepared by the American Board of Plastic Surgery which is one of 23 specialty boards approved by the American Board of Medical Specialties and the only board approved to provide certification in all aspects of cosmetic surgery.

In order to remain current in his daily practice, the plastic surgeon is required to complete programs of continuing medical education including detailed courses of instruction in current topics of cosmetic surgery. Because of these specific requirements of training, certification and continuing education, the plastic surgeon stands alone as the medical specialist best qualified to provide for safe effective surgical care and for the safety of patients undergoing all aspects of cosmetic surgery. Thank you very much.

[Dr. Noone's statement may be found in the appendix.]

Chairman **Wyden**. Thank you very much.

Dr. Jarrett, who would you like to go next?

Dr. **Jarrett**. The next speaker will be Dr. Harvey Zarem.

Chairman **Wyden**. Doctor, I am going to have insist though that we stay within the 5-minute rule at this point, because we have a great many witnesses. We will make your prepared remarks a part of our hearing record though in their entirety.

TESTIMONY OF DR. HARVEY ZAREM, PAST DIRECTOR AND SENIOR EXAMINER, AMERICAN BOARD OF PLASTIC SURGERY, SANTA MONICA, CA

Dr. **Zarem**. Thank you. I am delighted, Congressman Wyden, to have the opportunity to appear before the members of the Committee on Small Business. I was very heartened to see that Congressman Sisisky from Virginia is the chairman of the Subcommittee on Exports. I have always thought that exportation would be an excellent solution of the problem of incompetent physicians.

We are impressed that the Federal Government is very concerned about a vendor on the street selling you Coca-Cola when you ask for a Pepsi-Cola, but apparently nobody is concerned about misrepresentation of qualifications in the field of medicine and surgery.

The license to practice medicine in most States is equivalent to the license to represent oneself as a specialist. I am a specialist in plastic surgery, but I may indicate in the phone book or in the ads in the papers that I am a neurosurgeon, or an orthopedist, or a psychiatrist of anything that I care to say that I am if I am licensed to practice medicine in the State of California.

This is one thing that is not often appreciated, not even by physicians, and it is really the root of the problem as far as I am concerned. Personal integrity and professional colleagues were at one time the censuring power in our communities to ensure honesty within the profession.

In medical school, we have all been taught over and over again to recognize our own responsibilities to the patient as our sole priority in caring for the patient. The classic ethical dilemma that was put to us in medical school was the issue of examination of the colon on a mass basis as a public health issue. It was shown that it was not economically worthwhile to have everybody have a colon examination, because the number of cancers detected was too small and it was not economically feasible.

But we felt as an individual physician, when faced with an individual patient, if we thought that it was appropriate for that patient, we would do so. This has been the emphasis throughout our medical training both in medical school training and even as adult and senior colleagues. Somehow this lesson has been lost in the present younger generation.

It is apparently difficult for many people in our society to believe that the profession is attempting to establish standards. What we never in the profession anticipated is the sociopathic physician without concern for the public or without concern for the patient, the physician who thumbs his nose at the public and thumbs his nose at the professional colleagues.

For those of us who are trained and certified, inappropriate professional behavior results in chastisement and ultimately withdrawal of certification. For those who are not trained and who are not certified, the profession ironically has no sanctioning power. It is the traditional concept of the preacher talking about coming to church to the people who are sitting there on Sunday.

The control of the unqualified physician remains in the State licensing boards. This issue is not a turf war. The issue is a standard of medical care. To pretend that it is a turf war is like calling the struggle between Al Capone and the FBI a turf war. We are trained in medicine to offer the patient the highest standard of care. If we cannot offer it, we are obligated to send the patient to someone who can.

These unqualified physicians are not offering their services in remote areas where there are no trained surgeons. Curiously, they congregate in the high density wealthy areas where trained surgeons are readily accessible. These physicians are not attempting to offer a service to the community, but they are impaired physicians, not by alcohol or drugs but by greed.

Finding a qualified surgeon in today's society is somewhat analogous to Diogenes' search for an honest man around the world. The American Board of Medical Specialties and its subsidy boards, including the American Board of Otolaryngology and the American Board of Plastic Surgery, have created an effective mechanism to protect the public. We are dealing today with physicians who are outside of this legitimate group within the profession, and therefore are outside of its control of standards. The public has to be informed and protected.

The American society has always focused on protecting the rights of the small businessman to learn a living. It is ironic that we are here to focus on protecting the right of the patient to be assured that he or she is in the care of a qualified physician. No physician has a right to earn a living at the expense of the patient's best interest.

I thank you for the privilege of talking to this committee.

[Dr. Zarem's statement may be found in the appendix.]

Chairman Wyden. Thank you very much, Dr. Zarem.

Dr. Jarrett. Mr. Chairman, our next speaker will be Dr. Norman Cole.

Chairman Wyden. Fine.

TESTIMONY OF DR. NORMAN M. COLE, IMMEDIATE PAST PRESIDENT, AMERICAN SOCIETY FOR AESTHETIC PLASTIC SURGERY; TREASURER, AMERICAN SOCIETY OF PLASTIC AND RECONSTRUCTIVE SURGEONS, LOUISVILLE, KY

Dr. **Cole**. Mr. Chairman, members of the committee and staff, I would like to address hospital credentialing as an indicator of competence. There is a nearly universal perception that physicians are regulated by State or Federal laws which define training and qualifications for those to present themselves as specialists. If we are to understand anything about what we are talking about today, we have got to begin by understanding that there are no such laws and there are no such regulations.

There is in fact nothing to prevent a physician regardless of training to present himself as a plastic surgeon, an aesthetic surgeon, a cosmetic surgeon, or a neurosurgeon, or any other designation that states or implies special qualifications.

In virtually every instance when these facts have been presented to the public, the response predictably and incredulous is, how can that be? The answer to that question is that up until recently, physicians have done a very good job of self-regulation. We have done so primarily through the hospital credentialing process which assures that a specialist could not practice in that hospital without meeting defined standards.

It is very important, Mr. Chairman, to recognize that the very existence of the unqualified surgeon operating in an unaccredited facility depends upon that physician avoiding at all costs peer review.

Both of the witnesses who appeared earlier, the injured parties, may have been well served if they had checked to see if either of the doctors, both the board-certified and the nonboard-certified, had privileges at an accredited hospital to do the procedures that they proposed to do. It is quite possible that the board-certified surgeon would not have had privileges to do liposuction. It would have assured them that the surgeons would have had medical malpractice insurance, because hospitals simply will not keep physicians on a staff that do not have medical malpractice insurance.

Mr. Chairman, the most meaningful assurance of quality today in plastic surgery or any other specialty is to subject the surgeon's training and experience to the scrutiny of other physicians, both surgeons and nonsurgeons alike. Such scrutiny, as you well know, is called peer review, and it is best accomplished in hospitals by the credentialing process that has been used very successfully for many years.

I would like to ask this question. How many in this room would be willing to fly in an airplane made by a manufacturer who says trust me, it is safe, we do not need a lot of Government regulations to build these things? When I ride in an airplane, I do so in the confidence that I know that it has been constructed in accordance with federally mandated guidelines and strict specifications. I know that it has been tested, and tested, and tested.

When a person goes to a plastic surgeon, they should be afforded the same assurances. What we have here is a field that does not have uniform guidelines or specifications. It has no program of uniform testing. What we have are physicians who are telling patients trust me, I am competent.

As an example, I am currently reviewing a medical malpractice claim that involves an obstetrician. This obstetrician took a 2-day course in fat suctioning, a weekend course, provided by one of the groups who is scheduled to testify later today. This obstetrician had absolutely no experience in any kind of body contouring surgery prior to that time. However, he presented himself to the patient as being capable of doing this procedure. He took the patient to surgery, and during the course of the operation he pushed the metal suction tube through her abdominal wall and ruptured her intestines and she almost died.

He undertook a procedure that was completely outside of his discipline for which he had no supervised training except to watch some cases on a television and tried to perform it on a patient who ended up being nothing more than a guinea pig, and who paid the price. A part of this obstetrician's defense in this case is that he had a legitimate right to do this procedure.

Mr. Chairman, this is a theme that you will hear over and over today, physicians testifying as to their rights to compete, their rights to do procedures, their rights to advertise, and their rights to have hospital privileges. This theme will be repeated from surgeons whose primary concern seems only to be certain to protect their own rights.

But what about the patient's rights, the patient's right to the assurance that the surgeon is really what he says he is, that a surgeon has been examined not only by his peers in his own specialty but by a hospital credentials committee which is made up of a diverse group of specialists outside of his specialty?

During this hearing, Mr. Chairman, I hope that you ask yourself how often am I hearing concerns raised with regard to the welfare of patients as compared to the concerns about the rights of surgeons to advertise and operate as they please.

In conclusion, legislation is urgently needed which will be directed at those who purposefully avoid or deny peer review standards governing the delivery of quality medical care. These physicians must be required to meet the same standards of training and qualifications that the public expects of a hospital-based surgeon.

Even if the practitioner intends to take these surgical procedures outside of the hospital setting into an office operating room, the public still deserves the assurance that the physician does meet hospital standards, and that if the patient so desired that the physician would be permitted to perform these same procedures in an accredited hospital.

Mr. Chairman, I believe that this subcommittee must determine which has the highest priority, the rights of these physicians or the rights of patients. To me there is no question that the rights of patients are paramount and must be the only priority and consideration. I believe that my attitudes are the same as any other truly qualified surgeon to accept and to conform to peer review and hospital credentialing standards to assure that the rights of the patients are protected.

I fully embrace the concept that my rights as a physician are subordinate to the rights of the patients. One has to ask oneself the question, why would any group of physicians try to do otherwise?

I thank you for your attention.

[Dr. Cole's statement may be found in the appendix.]

Chairman WYDEN. Dr. Cole, thank you very much.

Dr. Gorney.

TESTIMONY OF DR. MARK GORNEY, PAST PRESIDENT, AMERICAN SOCIETY OF PLASTIC AND RECONSTRUCTIVE SURGEONS, SAN FRANCISCO, CA

Dr. GORNEY. Rather than repeat my written testimony, I thought that I would take a different tack and show you rather dramatically, I hope, some pictures of the kinds of things that we are talking about which I think will make a much more significant impression on you than words. If I may have the first slide.

Mr. Chairman, as you well know, all of this began as far as we are concerned in the late 1970's or the mid-1970's when the Federal Trade Commission took it upon itself to review the entire medical industry for evidence of what they perceived to be anticompetitive devices. The story is amply familiar to you and I am not going to bore you with it, except to remind you in four very short slides that the FTC in 1975 issued a complaint against the various medical societies in which it stated their code of ethics basically prohibited the issue of advertising and were therefore anticompetitive.

In 1976, they sent subpoenas to all of the boards as a part of a broad investigation into alleged anticompetitive practices. In 1977, they focused in on plastic and reconstructive surgery and served us with a proposed order and complaint and relief order which was extensively negotiated but never signed and never agreed to. The FTC subpoenas included of course records of the American Board of Plastic Surgery including anything on the use of the term plastic surgery or cosmetic surgery by noncertified physicians. This was, as I said, never agreed to.

However, I think that the attitude of the Federal Trade Commission at that time is exemplified by one of the highest policymakers, a Mr. Greenberg, who stated plainly to the Newsweek magazine interview, "I will not deny the fact that some people go into brain surgery and have consequences that we all do not want. There will be costs, really serious costs." But he said that the benefits will be what was going on in the medical marketplace.

This unfortunately typified the attitude of the Commission at that time, despite the fact that we argued with them as vigorously as possible to the effect that they were opening up Pandora's box, the effects of which they could not possibly conceive of, on the end user, and the fact that they were emasculating our medical societies from any disciplinary action, and the fact that they were getting way out of their jurisdiction because unfortunately the economics in the marketplace did not work like they do with a product but a specialized highly individualized service that in most cases should be refused to one out of three people.

Surely enough over the next decade, I show you a cross section of the voluminous pieces of paper from all over the country—that were sent to me from all over the country, headlines indicating precisely what we had predicted, that is to say a wave of uncontrolled procedures done by marginally or totally untrained operators would result, and that this would in fact result in mayhem to the public, and that is exactly what has been happening. I think that you can read through yourself the kinds of headlines that we started running into.

Now there were some statements made at the time that the policy was being formulated that the Commission was making, but I think that you ought to read them in contrast so that you can learn what happens when policy is made in a total vacuum in Washington and what happens at the end to the end user.

This is something stated by Mr. Jonathan Gaines, one of the policymakers at the Federal Trade Commission, "When proposed methods are challenged, I think that the courts will come to demand the tangible evidence of actual harm."

I must warn the audience, particularly the ladies, that some of these pictures are going to be kind of raw and you might want to look away, but I have no other way of demonstrating the point that I am trying to make.

This is an ad, a plain ordinary garden variety ad much less noxious than the beautiful collection that staff has gathered there, but the kind of thing that existed in the 1970's. There is no reason that anyone should not believe what was being said there. This 40-year-old lady who had this problem, a little bit of fullness of the breasts and a little bit of hanging down—which I believe most ethical plastic surgeons would have said to her go home and forget about it—believed the ad and then wound up with this kind of a result. This is one example of the kind of thing that false and deceptive advertising can do.

Another statement made by the Federal Trade Commission, "Professional self-regulation through codes of ethics amounts to taking the law into your own hands defining very precisely the evil that you wish to examine," et cetera. Then it determined to what extent application of professional expertise decisions, political, social, or economic.

Let us examine that proposition for a second. Here is a typical ad of the kind that we have been seeing all along. Here is an individual who presented herself to a physician who was not a surgeon, complaining about a small blemish on her face, and he talked her into a facelift and converted her then to a horror mask, with which she will have to live for the rest of her life.

Another example. Mr. Gaines of the Federal Trade Commission said, "Quality is everyone's objective, but do not forget that not all consumers can afford the highest quality." Then Mr. Gaines suggesting that we should have several types of degrees, MD, MQ, and LQ for medium quality and low quality. I find that difficult to believe.

But here is a typical ad extolling the virtues of the magic that will occur when you have your nose fixed and beautified, and here are some examples of the kinds of results that come from that kind of thing. Here is one who, at the hands of an individual who had absolutely no training whatsoever except that his greed exceeded his ambition, and after seven operations wound up like this. The

University of California at Los Angeles surgeons after about 14 painful operations, were able to restore him to some semblance of humanity, but he is a psychiatric basket case.

Again, the FTC Chairman wants to know in this question whether these things are a matter of turf or whether they are medically indicated. Medically indicated, let us examine that proposition.

Here is a typical situation wherein takes an individual with a thick fat neck and does an operation called a neck lift. As you will notice, the incision is placed discreetly around the ears so that it is not visible and the result is an improvement.

This individual fell into the hands of a nonmedical specialty clinic at one of our universities in the West, again coming in for some unrelated matter, and she was told that she needed a chin lift, which I do not think that she does need any more than my 20-year-old daughter does. In fact, she believed them and she wound up with this kind of a result, and I challenge you to tell me the difference between the before and the after, except for the fact that they placed this kind of a scar on her neck.

If my freshman resident even suggested putting on this kind of a scar, I would tell him to make rounds on the way to the airport. I would fire him instantly, because this kind of nonsense shows absolutely no conception whatsoever as to what the plastic surgery criteria are.

Another quote from the Federal Trade Commission, again questioning the fact whether these restraints are really necessary to protect the public. Let us examine that proposition.

Here is a face lift done by an individual who was as thoroughly unqualified as he was unscrupulous. The lady was a heavy smoker which immediately was a contraindication. The thing was just poorly done. This is a gross technical error. Here she is seen from the other side. You can see in very real terms that what we are talking about is not theoretical, but we are talking about human beings who are being maimed and hurt all over the country.

Mr. Gaines again says that what was missing in these cases is evidence that something really bad would happen missing the restraints. Here is an ad which I challenge any sophisticated individual to tell me is not a perfectly bona fide ad. This individual wound up in jail in fact and had his license suspended after he took a 42-year-old lady and did his very first buttocks lift and wound up with a lady now who cannot stand, cannot sit, cannot have intercourse, and this is what happened. This individual who as this was being investigated, incidently, killed another lady in his office with cardiac arrest. He was thoroughly unqualified, but from his advertisement you would not be able to tell that. Here is another one, "I am a new woman, I am a new figure." If you look at the lower left, here is a lady who was in her sixties or seventies who has this kind of a problem, and they offered to put breast implants into her. If you do that, if you look at the lower left-hand picture, this is what happens.

So one asks oneself, what costs to the public is unfettered and uncontrolled advertising? When Mr. Pertschuk, the then Chairman of the Federal Trade Commission, said, "Clearly we have in this country a vestige of a medieval guild system which prices, entry, and professional standards are set by the professions themselves with a classically unhealthy competitive situation," without even hinting who indeed should set the standards.

We asked him again, just what do you consider an unfair advertisement? Part of the answer was any advertisement that is misleading or deceptive, but that unfortunately is not defined. We asked, how fast do your new powers allow you to act, and he said that it was as fast as his lawyers could write that he could correct the situation. Unfortunately, there are some rather slow-writing lawyers at the Federal Trade Commission. Because as of 1977 when we formally asked the Bureau to help us control this plague that we have gotten what only charitably can be described as an extremely cool reception, and nothing really has happened. However, the hucksters are losing no time in letting the public know that the Federal Trade Commission is indeed taking strong measures against the AMA and the Society of Plastic Surgeons to create competition.

This is the end point, Mr. Chairman, to which advertising arrives at the houses unsolicited. At everyone's house in the Long Beach area there arrived a bunch of coupons with 50 cents off on salami, and $1 off on shoes, and a discount on a plastic surgery consultation. That is the level to which we have arrived.

I think that the heart of our case, oddly enough, is much more eloquently stated by Mr. Justice Burger reporting the previous Supreme Court decision in which he said:

> The legislature was not dealing with traders in commodities, but with the viable interests of public health, and with a profession treating bodily ills and demanding different standards of conduct from those which are traditional in the competition in the marketplace. The community is concerned with the maintenance of professional standards which will insure not only competency in individual practitioners, but also protection against those who would prey upon a public peculiarly susceptible to imposition through alluring promises of physical relief. The community is also concerned with providing safeguards not only against deception, but against practices which would tend to demoralize the profession by forcing its members into an unseemly rivalry which would enlarge the opportunities of the least scrupulous.

Lastly before closing, Mr. Chairman, I would like to show the committee just exactly how easy it is to bamboozle the public with advertisements. Here is an ad which, like most ads that show before and afters, shows a different pose, a different lighting, and a different individual with all kinds of lighting trickery being done. In fact, what we did in order to show you how easy it is to do that is, we took my picture and I did not wash my hair for a few days and then we fluffed it out with thickening shampoo, recombed it and took a picture.

Now Mr. Chairman, the previous picture that I showed you has a registered title for it. He calls it MPR, which stands for microprocess reduction something, and it is registered. This other one incidently costs $12,000 to $20,000 to do. I am thinking of registering a title for this procedure, Mr. Chairman, and I am going to call it MPC, and it stands for My Pocket Comb, and it costs 25 cents. Thank you.

[Dr. Gorney's statement may be found in the appendix.]

Chairman **Wyden**. Doctor, thank you very much. Your testimony and that of all of you in the association has been very helpful. Dr. Gorney, let me begin with you if I might.

Is it your view that the number of hucksters, and quacks, and charlatans is growing at a rapid rate in the cosmetic surgery field now?

Dr. **Gorney**. Almost at an exponential rate, Mr. Chairman. It is growing very, very fast.

Chairman **Wyden**. It is growing at a very fast rate?

Dr. **Gorney**. Yes, sir.

Chairman **Wyden**. It is your view that many doctors are attracted to this field at this point?

Dr. **Gorney**. Mr. Chairman, I made a statement to the Wall Street Journal which I would like to repeat to you here. One of the problems is that with the constrictions on the income of the average physician by the changes in third party reimbursement which are occurring from Washington that doctors' incomes are being restricted. As you well know, plastic surgery is a vast important and expanding field, but what we are arguing about here is one very small segment, the aesthetic portion of it. Obviously that is a segment which all those insurance PPR's, DRG's, and all of that alphabet soup coming down from Washington does not effect.

So draw your own conclusion. Plastic surgery suddenly in the last 5 years is being viewed as the last refuge of the free-booter or the pirate who can charge whatever the traffic will bear, and that is one of the things that is happening.

Chairman **Wyden**. It is your view that the Federal Trade Commission has contributed significantly to the rise of the growing rate of charlatans and the free-booters as a result of their policies?

Dr. **Gorney**. Regrettably I can come to no other conclusion, Mr. Chairman. In addition to which, the Federal Trade Commission in its infinite wisdom decided at the beginning that the reason for this was to bring down the cost of surgery, but it has done nothing of the sort, it has done exactly the opposite, because the economics of the marketplace do not work the same way in the medical marketplace.

There is one physician whose picture I showed you who is spending at least $175,000 a year on one advertisement in one location. He is spending approximately a quarter of a million dollars all over the State for the year. Now if other plastic surgeons were to respond to that kind of pressure, where is that money coming from except from the Nation's pockets, and how is that going to reduce the cost of surgery? It has done nothing of the kind.

Chairman **Wyden**. Now your association has been meeting with the FTC, I gather, off and on for something like a decade. I note that in January 1979, for example, that officials of your society met with Los Angeles regional director, Harvey Sapperstein, and you discussed these issues.

Dr. **Gorney**. Yes, sir.

Chairman **Wyden**. What has been the FTC's response? Have they said for example that this is not a Federal matter, the advertising, that advertising is just a local concern?

Dr. **Gorney**. Mr. Chairman, I can characterize their response by saying do not call us, we will call you. They have been very cool in their response. In one instance which had to do with some fake face lifts that were being done by laser, they did come forth and helped to stop that practice. But the problem is much more urgent.

Mr. Chairman, I feel that the problem is much more urgent than how much sugar is in children's cereals which they are very concerned with.

Chairman **Wyden**. I think that there are a variety of issues that are important, but it just seems to me that false and misleading advertising goes right to the heart of the problem and their responsibilities. What you are saying is that for more than a decade that they have expressed no interest in following up on some of these ads and questionable promotional material.

Dr. **Gorney**. We would hope to establish a working relationship with the Federal Trade Commission. Because we really feel that with having helped start this that it is part of the responsibility to help us control it. We are eager and we want to control it, but we are getting a very cool reception, Mr. Chairman.

Chairman **Wyden**. I think that you are right to say that you hope to establish one, but after more than a decade of trying to do it, you have not established a working relationship to the point that they follow up on deceptive advertising that you present to them, is that not right?

Dr. **Gorney**. We are in the process of establishing that kind of relationship. We have a liaison with them.

Chairman **Wyden**. I am not sure that the American consumer can stand waiting any longer for the Federal Trade Commission. Because after a decade—and it is my understanding that it is not just your group but that others have tried to get this agency to move—for more than a decade. I just think that it is unconscionable foot dragging.

Are we at the point now where a significant amount of cosmetic surgery is just being sold like a bar of soap, or a tube of toothpaste, or a used car?

Dr. **Gorney**. Very much so. I showed you those ads where people are soliciting by direct mail. It is being touted as totally harmless and very risk free. Look at those ads over there and that will answer for itself.

Chairman **Wyden**. So it is your view today that as a result of lax regulation and practitioners touting credentials that they do not have that there are a significant number of consumers that are undergoing cosmetic surgery that is unnecessary and dangerous?

Dr. **Gorney**. Unnecessary is a very broad term. But we believe firmly, all of us, that motivation for elective aesthetic surgery should come from within and that it should not be suggested from without, and that the surgery is being done precisely because of commercial pressure rather than the patient's own desire to have it done. I think that Dr. Jarrett has summarized pretty much the recommendations to the committee, which you might want to look at.

Dr. **Jarrett**. With your indulgence, Mr. Chairman, may I give some recommendations that we have regarding some of these issues?

Chairman **Wyden**. I did hear the recommendations, Doctor. Let me if I could go on because time is short. But we appreciate your recommendations and they are going to be made part of the record.

Dr. Gorney, what percentage of members within your society in your view are doing cosmetic surgery that they are not qualified to perform?

Dr. **GORNEY**. I could not begin to guess that, but I would imagine it to be a very small amount. All plastic and reconstructive surgery residencies demand a certain level of expertise in that field, and there are quarterly reports that have to be sent to the board. If there are not enough cases being done in the residency training program, that residency program hears from the board very quickly.

Chairman **WYDEN**. Let me follow up then with you, if I could, Dr. Jarrett.

It is my understanding that there have been something like 170 instances since 1980 where plastic surgeons have been charged with various kinds of wrongdoing, is that correct?

Dr. **JARRETT**. That number could be accurate. We have a very strict and active code of ethics on our Judicial Council. I can say that since 1980 that we have suspended four members, we have publicly censured eight members, and we have formally expelled four members of our organization.

The surgeon who operated on one of the patients today who said that he was board-certified did meet the academic requirements and was certified but did not qualify for membership in ASPRS because of a failure of his ethical and moral standards.

Chairman **WYDEN**. What happened to the remainder of the 170 plastic surgeons who have had charges presented to your association?

Dr. **JARRETT**. Every one of those charges is very carefully evaluated by our Ethics Committee. Most of those have to do with advertising problems. After the Ethics Committee evaluates them carefully and openly, they refer questionable ones, ones that they think represent infractions, to our Judicial Council where a final hearing is held and disposition is rendered.

Chairman **WYDEN**. In how many instances has disciplinary action been taken with respect to questionable advertising by your association?

Dr. **JARRETT**. I cannot give you a specific number, but I can say that since 1980 that there have been about 16 formal actions taken.

Chairman **WYDEN**. With the bulk of them being related to advertising?

Dr. **JARRETT**. The bulk of them relating to advertising, yes.

Chairman **WYDEN**. Now Doctor, you drew a sharp contrast between the Board of Plastic Surgeons and the Board of Cosmetic Surgeons. The founders of Board of Cosmetic Surgeons say that their board is at the same place that yours was when it first started back in 1938. They say that it is just a matter of time before they, too, are ABMS approved and their route to approval is not particularly different from that of your own society.

How would you respond to the assertion of the Board of Cosmetic Surgeons?

Dr. **JARRETT**. I do not see any similarity at all between our two boards at any point in time. As you have been told by Dr. Noone, our board requires a minimum of 5 years of formal residency training by ACGME accredited programs. The stated membership in their board requires residency in some recognized board followed by the performance of 1,000 cases of cosmetic surgery and then passing an exam.

That board would be obstetrics and gynecology, it could be family practice, it could be neurosurgery, it could be cardiology, it could be anything unrelated, it could be internal medicine. But if they are an approved certified member and if they perform 1,000 cases then they qualify.

Their residency training did not prepare them to do, in many cases, any cosmetic surgery. So what proof is there that those 1,000 cases have been properly performed. We see their training requirements as absolutely no guarantee of quality and are nothing more than a deception to lure the public into their offices.

Chairman WYDEN. Let me ask one more question of you, Dr. Jarrett, and then I want to recognize my colleague. Doctor, there are a fair number of ads from plastic surgeons on posters.

Is it your view that the policies of the Federal Trade Commission have contributed to what could be called a vicious circle in which qualified doctors, particularly younger ones who may come out of school owing a great deal of money, and that they may be in effect abandoning ethics and taking this Madison Avenue approach to advertising, just because they feel that they have got to compete?

Dr. JARRETT. They are stretching the limits of the ethical requirements to the limit, because they feel that they need to compete with the other ads that come out.

Dr. GORNEY. May I add one word to that, Mr. Wyden?

Chairman WYDEN. Please.

Dr. GORNEY. There are individuals coming out of New York. I would ask you to sometime peruse the yellow pages in plastic surgery in New York City, and you will not know whether to laugh or cry. All of the people who are coming out of residency in the New York area will tell you flat out that what they are going to need besides the money to set up their practice is an extra $25,000 to $50,000 for their first year public relations and advertising or they are not going to survive.

Chairman WYDEN. The gentleman from Virginia.

Mr. SISISKY. Thank you, Mr. Chairman.

I enjoyed your presentation. You made a point about peer review and hospital credentials.

Do any of these advertising surgeons or cosmetic surgeons have hospital privileges?

Dr. COLE. Mr. Sisisky, there are some who certainly do have hospital privileges. Hospital privileges are directed according to one's qualifications in terms of being able to perform certain procedures within a hospital environment. There are ear, nose and throat surgeons, there are dermatologists, there are gynecologists who have hospital privileges. Having those hospital privileges, at the same time the credentials committee defines what procedures they are authorized to do under those credentials.

I have privileges in my hospital. But having surgical privileges there does not permit me to do neurosurgery in that hospital. So as a consequence, the mere having of hospital privileges by themselves may not serve the public well if you do not ask the second question. The second question is are the procedures that you may be proposing to do outside of the hospital also procedures that you could perform in the hospital.

There is the deception. To say that I have hospital privileges, therefore I must be all right, and then to find out that they do not have any privileges. Just like the surgeon that we were talking about earlier for the individuals who were injured. They may not have had the privileges to perform those procedures in the hospital. It is incredibly important that that distinction be made.

Mr. **Sisisky**. I agree with you. I used to serve on hospital boards. I just wanted you to bring it out.

Internally in the medical profession, and I asked the ladies the question—did they go to their own physicians or the county medical boards of whatever—do you send bulletins periodically to the physicians around this country to let them know what is happening out there? Does your group do that, or the AMA, or some group do that?

Dr. **Cole**. As far as internal publication within the medical profession itself, we have done our utmost through public education, and we have a very strong public education program, to try to alert not only the public but also our physician colleagues to some of the difficulties that we are encountering at the present time.

You mentioned, I think, in one of your questions that, had she asked the opinion of her family practitioner. We would urge them to do so. Because family practitioners and certain individuals involved in primary care are oftentimes very sensitive to individuals who are capable and those who are not. But aesthetic or cosmetic surgery is a very peculiar area. Individuals are sometimes embarrassed taking their concerns about their appearance to their family doctor, or to their obstetrician, or perhaps to their general surgeon. So they are very susceptible to trying to obtain a referral outside of that venue and go to these ads. We do not know how to get them to be more circumspect and go to the individuals who would give them that advice, who would give them the information that really would help them.

Dr. **Noone**. May I add, sir, that one of the functions of the American Board of Medical Specialties is to advise the public on physicians and specialty boards that are prepared to do this kind of surgery.

Mr. **Sisisky**. When you talked about advertising, it was that the American Board of Plastic Surgery does not approve of advertising. It makes a lot of sense, because it arouses unrealistic expectations, it is false and misleading, and it minimizes magnitude and possible risk of surgery which I think all surgeons could carry through, and it solicits patients for surgery which they might not have otherwise consider.

Was this written when the advertising first came out when the FTC allowed it or is this something new?

Dr. **Cole**. No; that was part of our creed early on. One of the things, sir, is to recognize that we can only create regulations and requirements that affect our members.

Mr. **Sisisky**. I understand.

Dr. **Cole**. One of the most famous and visible cases of a complete advertising campaign which was very successful in New York was by an individual who purposefully never tried to obtain his boards, never tried to obtain membership in any organization, and thereby he became immune to any sort of sanctions by any of the organizations that had rules and regulations that were against that.

That is one of the problems that we are encountering, and that is why we think that in some way, with legislation or otherwise, that there has to be a larger hand on this matter.

Mr. SISISKY. I served on the State legislature before I came to Washington some 7 years ago, and I was in a battle all of the time on ophthalmology and optometry and things like that. A lot of people have charged basically that it was done for competitive reasons, that the ophthalmologists were trying to protect their turf. While you were testifying, it just dawned one me that some 3 years ago that I had a little growth here on my eye and I had my wife call a plastic surgeon, and they simply said that it would take 3 to 6 months to get it done unless it were an emergency.

You have no problem in your field getting patients, am I correct in that, it really is not a competitive thing?

Dr. COLE. I think that the whole issue of competitiveness is an interesting issue to bring into the marketplace. I do not know why it took so long for you to get an appointment. I think that in my office that if it had taken that long that I would have expected the patient to insist, listen, I need to have that taken care of more quickly, and I could have made a referral. I think that is what I think that an individual would do.

But competition in the marketplace has been something that individuals have said this must be done and that the FTC has done it. I recently read an editorial written by Dr. Richard Webster in the Cosmetic Surgery Journal which was written some time ago, in which he urged unfettered competition in the marketplace as a feature of the American system, that that is what we ought to be doing.

Dr. Webster, I believe, is scheduled to speak to you later in these hearings. I have the greatest respect for Dr. Webster as a surgeon and I understand some of the things that have happened to him and some of the frustrations that have led him to write and say some of the things that he has said.

However, I think to suggest that unfettered competition has a place in the medical marketplace is one of the most irresponsible suggestions that I have ever heard. Unfettered competition may be appropriate in the area of consumer goods. If I get a product that is unacceptable or unsatisfactory, I can return it or I can throw it away and the only loss to me is financial. But the results of an unacceptable or unsatisfactory surgery are permanent damage and disability. Financial losses in these circumstances become very secondary and often insignificant, in my opinion, in comparison.

The question is, how many people must be unnecessarily injured in the process as we sort out the competition? Whereas, I believe that the public very well may benefit from unfettered competition in consumer goods, but I believe that they must be protected against unfettered competition in the medical marketplace when the result can be and often is permanent disfigurement.

Mr. SISISKY. I am glad that I raised the question. Nobody proposed that I do that, but I am glad that you had the opportunity.

Because I felt that somewhere in this testimony that competition would come in.

Dr. Jarrett, I looked in your testimony, and you had some recommendations. If you would not take too long, would you mind?

Dr. JARRETT. I would like to give our final negotiations. I will just omit the testimony that I was going to state at this time. My initial opening comments were just opening comments.

But in conclusion, in my position as president-elect of our society, I would like to submit to the subcommittee and to the chairman five recommendations.

Number one, that only boards recognized by the American Board of Medical Specialties should be allowed to exist. Within the current 23 recognized boards, this would include officially sanctioned cosmetic surgery training within two of those boards, the American Board of Plastic Surgery and the American Board of Otolaryngology, representing cosmetic surgery of the face.

Recommendation number two, all outpatient surgical facilities should be accredited by an official accrediting agency.

Number three, physicians performing cosmetic procedures in their office facilities should be limited to only those procedures for which he or she has privileges in a fully accredited hospital.

Number four, all advertisements stating that a physician is board-certified must name the certifying board and whether or not it is recognized by the ABMS or merely one of the 104 self-designated specialty boards. That is if option number one is not taken to eliminate those boards.

Number five, encourage the FTC to adopt strict advertising guidelines along the lines that several States have recently done, such as California which has specifically restricted what may or may not be advertised.

Mr. SISISKY. Thank you.

Chairman WYDEN. Dr. Jarrett, with respect to your recommendations, are there any additional recommendations that you have other than the ones in your prepared testimony?

Dr. JARRETT. Just those five that I gave.

Chairman WYDEN. Very good. Let me just ask a couple of other questions then if I could.

Dr. Gorney, in your view, has the age of advertising in medicine encouraged in effect one-upmanship in cosmetic surgery—your board versus my board, your photographs against my photographs, your specialty against mine? Are we seeing a kind of one-upmanship coming into cosmetic surgery with the patients being the losers?

Dr. GORNEY. We have seen it in spades, and that can result in nothing but confusion to the consumer. Mr. Chairman, we have realized that there is no point and it is dangerous to point fingers at complications of others. I am sure that this afternoon that you will see from the other side all kinds of catastrophes and difficult problems that we have created. It is not exclusive problems. Everyone has complications. Anyone who does not has a pact with the devil or has not done enough surgery.

The point is that a great number of the catastrophes that we see were caused by criteria which were basically economic, in other words a normal temperature and a valid credit card were the only criteria to bring that patient in.

It is the duty of the plastic surgeon and the cosmetic surgeon to evaluate the patient in all possible ways, psychological and physical—is that individual fit for that surgery and is that individual going to benefit from that surgery? That is totally incompatible with advertising. Because when you advertise and you are spending a million bucks getting a campaign on, you have got to rope in everything that will come along and use counselors to go out there and hustle, because otherwise you are not going to make it, and that is the quickest road to perdition that I can think of.

Chairman **Wyden**. Doctor, thank you. Let me just ask a couple of additional questions, and then I want to recognize our colleagues in the minority.

Doctor Zarem, I think that many Americans are going to be surprised and frankly quite alarmed to hear that any doctor with a medical degree and State license can go out and do everything from brain surgery to cosmetic surgery. So we have the situation today where dermatologists, obstetricians, gynecologists, otolaryngologists, osteopaths and others are doing cosmetic surgery—literally everything from face lifts, and nose jobs, to breast enlargements and tummy tucks.

It seems to me and I gather that this is part of your testimony that we now have a lot of practitioners, a lot of doctors, in effect, doing surgery out of the field today as a result of the advertising boom and what we have heard about today. Is that your view?

Dr. **Zarem**. That is absolutely my view, and I think that the key to this issue that we are here to discuss today is that it is out of their field, and beyond their area of qualification, and beyond their training, and beyond their capabilities.

Chairman **Wyden**. Dr. Cole, just one question for you. I have had a special interest in medical peer review, and was the author of the Health Quality Improvement Act that gives legal protection to physicians who blow the whistle on a colleague who they feel is incompetent, as a result of a widely known case in Astoria, OR, that had great impact on peer review.

But it seems to me that what you and your colleagues are saying is that traditional peer review does not really apply to cosmetic surgery, because you have the self-declared specialties, and so many people springing up doing it in their office.

Is that essentially your concern about peer review?

Dr. **Cole**. Mr. Chairman, that is precisely the concern. Precisely our concern is that this type of surgery is a very unique and unusual type of surgery that can be performed almost entirely outside the confines of normal peer review. When you get a group out there that is devoid of any peer review, then you better lock the door. Because in those instances, they are not subject to anyone looking over their shoulders and saying hey, you have got to slow down. That is not appropriate.

We are concerned about the best interests of the patients in these instances. You have got to ask what is the best for the patients. I welcome individuals looking over my shoulder. I think that it is essential to keep me on line. I think that every other surgeon and every other physician that I know wants that to be in place to protect their patients. Only those who make a living outside of that do not want peer review. That is what I hope that this committee will look to.

Chairman **WYDEN**. Dr. Zarem, is it your view that it is not ethical to practice medicine without malpractice insurance?

Dr. **ZAREM**. It is a very irresponsible thing to do, and today it is my understanding that those who do practice medicine without malpractice insurance do so because the insurance companies refuse to insure them. Considering that the insurance companies are in business to make money on medical insurance, you can only conclude that the reason that they would refuse to insure them is because they have proven themselves to be a risk that is not acceptable.

Chairman **WYDEN**. But the practice of going bare seems to be widespread in the cosmetic surgery area, is it not?

Dr. **ZAREM**. I am not able to answer that in terms of numbers. But again in the medical profession, the majority of people that go bare, so to speak, do so because they do not have a choice, because they are not insurable because they are undertaking procedures with undue risks and are having suits against them beyond the ordinary.

Chairman **WYDEN**. Dr. Gorney, do you want to add anything?

Dr. **GORNEY**. Yes, sir. I wanted to add that aside from my private practice and teaching obligations that I am also a part-time medical director of the largest medical liability carrier in the West. I can tell you for a fact that at least in California that you cannot get hospital privileges unless you do have malpractice insurance, which again forces you to work in an outpatient private facility.

I think that unless you have a tap line to the devil that it is irresponsible not to carry malpractice insurance, because you know that something is going to happen to you, no matter what.

Chairman **WYDEN**. But you are of the view that it is widespread that practitioners do not have malpractice insurance in these various outpatient settings where cosmetic surgery is being performed?

Dr. **GORNEY**. Regrettably I have to agree with that.

Chairman **WYDEN**. Does the gentleman from Virginia have any additional questions?

Mr. **SISISKY**. I think that staff does.

Chairman **WYDEN**. All right. Let me recognize the minority at this time.

Mr. **RUSSINOFF**. Thank you very much, Mr. Chairman. We appreciate your indulgence. I would like to thank the doctors for being here on behalf of Congressman Broomfield and Congressman Hancock. I just have a few brief questions.

Let me start with Dr. Jarrett. You had mentioned earlier that there were four members of your society who lost their membership?

Dr. **JARRETT**. Expelled from membership, correct.

Mr. **RUSSINOFF**. Did they also lose the ability to practice medicine or their medical licenses?

Dr. **JARRETT**. I doubt that very much. I do not have those details. A member can be expelled from our society for just doing false and misleading advertising, and that would not affect his right to practice medicine.

Mr. **Russinoff**. Could you compare the credentialing of your organization with some of the others who are going to be represented here today?

Dr. **Noone**. I think that I can probably speak about that. The American Board of Plastic Surgery—all physicians who are members of the American Society of Plastic and Reconstructive Surgery must be certified by the American Board of Plastic Surgery. The credentialing starts with a residency program which is a minimum of 5 years in duration followed by examination and then certification. The American Board of Plastic Surgery is looked at very carefully by the other medical specialties, namely through the American Board of Medical Specialties.

So this overall group looks at the American Board of Plastic Surgery very carefully to make sure that the American Board of Plastic Surgery functions and credentials its members properly. The other groups you may hear from today are not approved by the American Board of Medical Specialties, which is the overall credentialing body in United States medicine. I think that is the big difference.

Why not is because they are not approved because they have not developed residency programs through the approved structure of residency training in order to become approved by the American Board of Medical Specialties.

Mr. **Russinoff**. One last question.

What other procedures do your physicians perform other than cosmetic surgery?

Dr. **Zarem**. The members of the American Society of Plastic and Reconstructive Surgery have been certified by the American Board of Plastic and Reconstructive Surgery. As such they have had to go through a defined residency training program that includes formal teaching and supervision in areas of basic care of the surgical patient, care of the injured patient both in terms of burns and other injuries such motor vehicle accidents, care of the congenitally deformed patients such as clef lip and clef palate, care of the truncal deformities including the breasts and working with breasts, cancer patients and reconstruction, care of facial deformities including cosmetic procedures such as rhinoplasty eyelids, face lifts, et cetera, as well as surgery of cancer of the head and neck region or skin.

So the training is a broad-based general surgical training as well as plastic surgery training, focusing down on plastic surgery as a skill.

Mr. **Russinoff**. So we are talking about a considerable number of additional procedures besides just general cosmetic.

Dr. **Gorney**. May I add a footnote to your question, sir?

Mr. **Russinoff**. Sure.

Dr. **Gorney**. What you say is true, but do not forget that every faculty member is in a residency program. There are usually a number of people; that their private practice is with most of the senior people; that the bulk of their practice is aesthetic cosmetic cases and the residents scrub on all of that. So besides the reconstructive stuff, most plastic surgery residents in the approved residencies get an enormous amount of exposure to cosmetic surgery in a fashion which is graduated responsibility.

They do not go to a hotel weekend course and read about it and then start trying it out. First they look, and then they assist, and then they tie stitches, and then they start making incisions, and then they start doing part of the operation, and finally in their senior year they start doing the whole procedure. But all of that time they are exposed to several attending physicians' large program of aesthetic surgeries. All you have to do is go look at any day's program in any plastic surgery residency program in the Washington area and you will see that.

Dr. NOONE. I would like to add another footnote which I feel is important also to that question, and that is an important question. In order to do cosmetic surgery and in order to have advances in the field of cosmetic surgery, the other aspects of plastic and reconstructive surgery come into play. What I mean by that is that if you are doing a face lift on someone, you cannot really do the face lift without regard for the other structures of the face, the function of the muscles, the function of the bone interfaces, the control of the nerves, et cetera.

If you are doing a suction procedure on someone's fat in her hips, you cannot do this without knowing things about shock, fluid loss, blood replacement, and other aspects of general abilities in medicine and in surgery. That is why our training is so long. That is why we spend so much time learning other aspects of surgery and learning other aspects of plastic and reconstructive surgery, because you cannot do reconstructive surgery without a concern with cosmetic appearance, and you cannot do cosmetic surgery without a deep knowledge of reconstructive surgery. That is a very, very important distinction that we have to draw.

Dr. COLE. If I may say one thing as well. That is that I think that it is incredibly important that this subcommittee understand the whole specialization process. We have 23 boards. What that really says is that individuals have gone into a particular discipline, that it is no longer possible that a physician can understand all of the intricacies of the human body diseased and otherwise. So we choose to go into one discipline.

That discipline starts out by developing a basic core of knowledge. Once we have developed that core of knowledge, then we can expand on that core of knowledge with new advances and otherwise. But where we have a lot of difficulty is when an individual has developed a core of knowledge and a discipline and then chooses to move outside of that discipline completely and try to do a procedure that is totally outside of that discipline.

As an example, the American Board of Otolaryngology has stated on their own stationery that with regard to breast augmentation mammaplasty that the board does not believe that this is within the purview of the specialty of otolaryngology head and neck surgery. Yet when an otolaryngologist undertakes to increase a woman's breast and they are doing it and that is the concern that we have that he is acting in direct opposition to their own board.

It even demonstrates the fact that the boards and our own internal mechanisms are not working in these situations. That is something that we need help with.

Mr. **Russinoff**. How many members are in your organization again?

Dr. **Jarrett**. Three thousand two hundred.

Mr. **Russinoff**. Three thousand two hundred, OK, and basically most of the physicians practice in an outpatient setting?

Dr. **Jarrett**. Our members practice in hospitals and outpatient facilities. Across the Nation, I would estimate that the majority of our members' surgeries are performed in hospital environments.

Mr. **Russinoff**. Can you give me a ball park figure?

Dr. **Jarrett**. I would say two-thirds.

Mr. **Russinoff**. OK; thank you. No more questions.

Chairman **Wyden**. Are there additional questions from the minority?

[No response.]

Chairman **Wyden**. Gentlemen, if you do not have anything that you would like to add further, we will excuse you at this time. You have been most cooperative with our subcommittee, and we are very appreciative. Thank you.

We would now like Dr. Weissman and his counsel, Mr. Robert K. Tannenbaum, to come forward. We welcome you to the subcommittee. We have per our understanding with you some formalities that we will have to deal with first.

Let me just state for the record that the next witness before the subcommittee is Dr. Donald Weissman, a cosmetic surgeon practicing in Los Angeles. Dr. Weissman has asked to testify before this subcommittee and per his counsel, Robert Tannenbaum of Los Angeles, in a letter to the subcommittee dated March 28, 1989, has made a formal request that Dr. Weissman be permitted to testify today before the subcommittee.

Dr. Weissman has asked to testify before the subcommittee today to address charges made by an editorial documentary prepared and shown by KCET-TV in Los Angeles on or about October 31, 1988. Dr. Weissman says that the documentary stated that and I quote, "He was unfit to perform cosmetic surgery, injured a patient, Donna Barone, and refused to be interviewed." It is Dr. Weissman's position that, and I quote, "The program has created and disseminated false and defamatory impressions about me."

Dr. Weissman is appearing today before the subcommittee at his own request. Pursuant to his further request that he did make of the subcommittee, he is accompanied by counsel and as a courtesy to the witness his counsel will be permitted to sit beside the witness and to advise the witness. If necessary the Chair will permit a short recess to allow counsel to consult with his client. But the Chair does wish to emphasize that counsel is not here as a witness today before the subcommittee, and Dr. Weissman and Dr. Weissman alone is here as a witness—again the Chair wishes to point out—at his request, to otherwise address himself to the members of the subcommittee.

With those as formalities, Dr. Weissman, it is the practice of our subcommittee to swear all witnesses today.

Do you have any objection to being sworn as a witness?

Dr. **Weissman**. No.

Chairman **Wyden**. Please rise and raise your right hand.

[Whereupon, the witness was duly sworn.]

Chairman **Wyden**. Now before Dr. Weissman presents his sworn testimony, the subcommittee will show those portions of the film that refer to Dr. Weissman in order to give members and staff as well as others present an understanding of Dr. Weissman's concerns. We will do that at this time, Dr. Weissman, and then we will have you present your statement.

Mr. **Tannenbaum**. Mr. Chairman, may I, with the Chair's indulgence, make a comment with respect to the film?

Chairman **Wyden**. Yes.

Mr. **Tannenbaum**. I specifically have a letter from KCET that was written by the vice president and general counsel. It is a letter written on February 16, 1989, to Dr. Jeffrey Alan Kline, who was also involved in part of the program. It indicates on page 2:

> One additional point of your letter should be addressed specifically. KCET has not authorized any plastic surgeons to reproduce or publicly exhibit the program. Any such unauthorized reproduction or public exhibition constitutes an infringement of KCET's copyright and we will be pleased to inform any infringer of the civil and criminal remedies for the copyright infringement.

Moreover, I requested in a letter dated March 30 that the airing of the tape is defamatory. One of the reasons that we are here is not to get involved in the overall issues that you have been addressing this morning, but because at least three of the members I am informed by staff have already seen this film. We wanted an opportunity to demonstrate to you that parts of it are defamatory as they relate to Dr. Weissman. We certainly have no objection to you viewing it in camera, but the constant republication of it is defamatory.

Chairman **Wyden**. I am sorry, what was that, you have no objection?

Mr. **Tannenbaum**. We have no objection to you viewing it in camera, as I indicated in my letter to you, Mr. Chairman, but we do have a problem with respect to it being shown for public dissemination and consumption given the nature of its defamatory content.

Chairman **Wyden**. We will put that into the record. It is our understanding that the producer has no objection to having this film shown at this time. I would also advise counsel that Dr. Weissman asked to come to this subcommittee. As a courtesy to your client, we have agreed to do it. That counsel has been advised that this was the arrangement that was agreed to. That if Dr. Weissman were to testify, that this would be shown.

Mr. **Tannenbaum**. It was never the understanding. What I asked from staff was whether or not you intended to show the film, and I was told that certain segments would be shown. That was the motivating reason and the inducing cause for us to come here from California. Moreover, Mr. Chairman, again I was informed by staff that at least three members of the committee have seen it, and we wanted to dispel under oath before you, voluntarily coming forward from Dr. Weissman the notions of what we believe to be defamatory. After all, the people who were in the film are not under oath and they are not before your committee.

Chairman **Wyden**. We will take a break here for just a moment. If you will stay at the witness table for just a moment, we are going to take a quick break to pursue this with counsel.

Mr. **Tannenbaum**. Thank you, Mr. Chairman.

[Recess.]

Chairman **Wyden**. Do you have any objection to being sworn as a witness this morning?

Ms. **Bryant**. No; I do not.

Chairman **Wyden**. Raise your right hand.

[Whereupon, the witness was duly sworn.]

Chairman **Wyden**. Please sit down, Ms. Bryant.

TESTIMONY OF CLAUDIA BRYANT, KCET-TV, LOS ANGELES, CA

Mr. **Wyden**. You are from KCET-Television in Los Angeles, is that correct?

Ms. **Bryant**. That is right.

Chairman **Wyden**. Your station has no objection to this film being shown in any way, is that correct?

Ms. **Bryant**. That is right.

Chairman **Wyden**. It is the view of the station and your employer that this film is accurate in its material respects?

Ms. **Bryant**. That is right.

Chairman **Wyden**. All right. Thank you very much. You are excused.

Let me just state for the record that counsel is incorrect in saying that three members of the subcommittee have viewed the film, that is incorrect. So at this point, staff will show the film and we will then have Dr. Weissman make his prepared statement.

Mr. **Tannenbaum**. Mr. Chairman, just for the record, I just want to indicate that I was told that by one of your staff members. Second, in your letter to me—we appreciate the opportunity to come here for the reasons that I stated in my letter to you of March 28—but in your letter to me, so it is clear, that there was never any quid pro quo that if we came that you would be showing the film, quite the contrary.

Moreover, you indicated in your letter to me of March 29, the third paragraph of your letter, "At your attorney's request, you will be received to present your testimony at the subcommittee's hearing on April 4, 1989, to address the concerns expressed in Mr. Tannenbaum's letter." You are referring to my letter of the 28. So there was never any quid pro quo with respect to you showing it.

Chairman **Wyden**. For purposes of the record, what the Chair has said is that Dr. Weissman has asked to testify before the subcommittee. As a courtesy to Dr. Weissman, he has been permitted to do so. Staff will show the film.

Mr. **Sisisky**. Mr. Chairman.

Chairman **Wyden**. The gentleman from Virginia.

Mr. **Sisisky**. I have not seen the film. What good would Dr. Wiessman's testimony be if I have not seen the film?

Mr. **Tannenbaum**. I suggest most respectfully, Congressman, that it be done in camera, because the content we allege is defamatory. People who you will hear on the film are not under oath and they are not here before you, and they are not subject to cross examination. We heard from your staff that three members had seen it and that it was probably going to be shown today. Accordingly, we felt it necessary to come here. Otherwise, we would not be here.

So at no stretch of the imagination should you understand our being here that it was a quid pro quo that we wanted to show the film and that we are here to respond. We are here to respond because we were told that it was seen and that you probably would show it anyway.

Chairman **Wyden**. The staff will show the film.

[Film shown.]

Chairman **Wyden**. Dr. Weissman, at this time, you may make a statement, and we will make a prepared copy of any remarks a part of the hearing record in their entirety. If you could perhaps summarize your principal views, that would be very helpful.

TESTIMONY OF DR. DONALD WEISSMAN, LOS ANGELES, CA; ACCOMPANIED BY ROBERT K. TANENBAUM, ESQ., LOS ANGELES, CA

Dr. **Weissman**. Congressman Wyden and Congressman Sisisky, I am here today and I want to thank you for this opportunity for permitting me and my attorney to appear before you to give testimony. The purpose of my appearance is to set the record straight with regard to my competence, training, and experience as a cosmetic surgeon, and to respond to the false and defamatory impressions about me contained in the program viewed by some members of this committee and now viewed by all of us.

My understanding is that this committee is concerned with the quality, the competence, and the manner in which cosmetic surgery is performed in America today. I share that concern as well.

However, you must understand that no congressional committee or media producers have the right to defame American citizens. A distorted and unbalanced presentation of me has been presented to you. With your indulgence, I will now respond.

I believe that I am a highly qualified, skillfully trained, and successfully accomplished cosmetic surgeon. The good faith basis for my belief is founded upon the following: I completed formal training and chief residency in head and neck, ear, nose and throat and facial plastic and reconstructive surgery. My year as a chief resident was completed at Case Western Reserve Hospital. This training made me board-qualified not only in facial plastic and reconstructive surgery but cosmetic surgery as well.

I spent thousands of hours as an emergency room physician directing emergency room facilities. In so doing, I personally engaged in the diagnosis and acute care of virtually every sort of medical and surgical emergency.

I spent 2 years in a preceptorship/mentorship with Dr. Alfred Koonin, a board-certified plastic surgeon; and Dr. Steven Gottlieb, a board-eligible plastic surgeon learning and performing various aspects of cosmetic surgery.

During the last 5 years, I have treated thousands of patients and performed thousands of surgeries. During the same period of time, I have been invited to lecture and present papers before national and international meetings and seminars including, but not limited, to the World Congress on Facial Sculpting in Cosmetic Surgery sponsored by the American Academy of Cosmetic Surgery. I presented a paper on Correction of Microgenia with Alloplastic Augmentation and Liposuction in Atlanta, GA, in October 1987.

At the Foundation of Facial Plastic Surgery, I presented a paper on Rhinoplasty and Proplast Implants in August 1986. At a meeting cosponsored by the International Oculoplasty Society and the American Society of Liposuction Surgery, the First World Congress on Dermabrasion, Chemical Peel, Liposuction and Soft Tissue Augmentation, I presented two papers, one on Refinements in Liposuction Surgery, and a second on Skin Excisions Combined with Chemo-Dermal Exfoliation for Acne and Traumatic Scarring.

At a faculty member and panel discussion at the American Academy of Cosmetic Surgery Symposium on breast augmentation, I presented two papers in Houston, TX in August 1986 on Submuscular Versus Subglandular Breast Augmentation, Pros and Cons, and Complications of Augmentation Mammoplasty, their Prevention and Treatment.

At the 24th annual meeting of the International Society of Aesthetic Surgery, I chaired the section meeting on Malar and Nasal Implants and presented two papers, one on Liposuction: The Current State of the Art, and one on Breast Augmentation: The Areolar Approach in Tokyo in May-June 1985.

At the First International Congress of the American Academy of Cosmetic Surgeons, I presented two papers in September 2, 1985, in San Francisco, one on Rhinoplasty in the Noncaucasian, and one on Mammoplasty in the Noncaucasian.

Most recently at the American College of Legal Medicine at a prestigious meeting in Palm Springs in March 1989 on Informed Consent and Cosmetic Surgery. I am a contributing coauthor of a book entitled Body Contouring Through Liposuction Surgery.

In late May 1986, I terminated the employment of one of my employees who without my permission or authority and in violation of my patients' rights of confidentiality, I have a good faith reason to believe, removed from my office information contained in my patient lists and some of my patient records. These stolen materials were subsequently given to State authorities who regrettably ratified this theft and randomly called my patients inquiring of them in substance if I had been unprofessional and/or whether I had engaged in some kind of misconduct, and whether they were satisfied with my surgery.

As a result of this official misconduct, coupled with the intervention and urging of a plastic surgeon, I presently am responding to lawsuits as you just witnessed out of the thousands of patients that I have attended and on whom I have performed successful cosmetic surgery.

Now with regard to the program For the Sake of Appearances, hereinafter referred to as the program, which I have been informed has been viewed and which were just viewed by members of this committee, and which has been disseminated to you by the American Society of Plastic Surgeons, the program has created and disseminated false and defamatory impressions about me.

Specifically, it wrongfully states that I am not trained or experienced in my specialty, cosmetic surgery, and that I refused to be interviewed on their program. I wish to inform this committee that I was indeed interviewed and desired to have my point of view heard. I was as forthcoming with the producer of that program as I am with you.

For some reason unknown to me, there was not one word uttered on that program voicing my side or point of view, and yet there were specific references to the fact that I refused to be interviewed. Furthermore, the program presents a former patient of mine who claims among other things that she presently has difficulty raising her left arm above her shoulder. I have with me today for your scrutiny medical documentation that will absolutely and unequivocally refute this claim. This patient is a litigious individual and has other cases pending, not with me.

Moreover, public records on file in the county clerk's office in Los Angeles reveal that she was charged with felonious grand theft, a violation of Penal Code Section 487(1), two counts, filed on September 29, 1982, in the Superior Court of Los Angeles, Case No. A378222. These records further indicate that she pleaded no contest to one count on December 14, 1982, before the Hon. Ricardo A. Torres.

Also on December 14, 1982, this individual, among conditions of her sentence, was ordered by the court to make restitution which I have every reason to believe that to date this has not been made.

Finally, I wish to submit to you a copy of my curriculum vitae listing my educational and professional background which I have just briefly summarized for you, and hope that it will shed further light on my qualifications and professionalism. I also want you to know that I would welcome a visit by any of you to my offices so that you can see the superb quality of my facility and the professionalism that I and my staff bring to it. Thank you very much.

[Dr. Weissman's statement may be found in the appendix.]

Chairman **Wyden**. Doctor, thank you, and let me ask you just a few questions at this point. Let me first of all just state for the record that the staff obtained the film not from any professional society but from the station itself.

Now Doctor, how many times did you perform breast surgery on Donna Barone?

Dr. **Weissman**. I performed breast surgery twice.

Chairman **Wyden**. Why were multiple surgeries necessary?

Dr. **Weissman**. This patient refused to follow post-operative care and instructions. One of the instructions after a competently performed surgery which was done, was to massage her breasts. She refused to massage her breasts and wanted her boyfriend to massage her breasts. When people do not massage their breasts they encapsulate. This is a well-known common phenomena. She encapsulated; and as a result of her encapsulation which was nonresponsive to conservative treatment, we went ahead and did a second surgery which is the standard form for that type of problem.

Chairman **Wyden**. Was the multiple surgery required to correct some complications from the first attempt?

Dr. **Weissman**. No; breast encapsulation is not a complication. It is an understood and well-recognized problem that can ensue after breast augmentation.

Chairman **Wyden**. Is it your view that the only——

Dr. **Weissman**. Excuse me, Mr. Chairman. Further, Ms. Barone was presented to with marked asymmetry and hypomastia small breasts. After surgery—and I am sorry that I do not have the pictures with me but I would be very happy to supply those photographs to you—she looked 100 percent better, and she was less asymmetric than she lied to in the program.

Chairman **Wyden**. We will hold the record open for any submissions as with all of our witnesses.

Mr. **Tannenbaum**. Thank you, Mr. Chairman.

Chairman **Wyden**. Is the only charge in your view, then, in dispute, regarding medical competence, is the question whether or not Ms. Barone can fully raise her arm?

Dr. **Weissman**. Ms. Barone can raise her arm. I have documentation here, and I would be very happy to provide it to you, by two of her own physicians, a chiropractic orthopedic and a neurologist. May I read that to you? It would take 1 minute, and it would certainly clarify this defamatory charge of this convicted felon. Let me just get to the point.

The patient in an examination performed after surgery by me approximately 1 year later as a result of a car accident where she claims to have been rear-ended, and this has nothing to do with her two slip and fall actions which she has filed lawsuits—as a result of this rear-end car collision, she saw a chiropractic and a neurologist, and here is an exact quote from the neurologist:

> Patient denies any paresthesia or prostheses in her upper extremities. Furthermore, patient denies any significant major medical illnesses. She had cosmetic surgery in the past, and she has a prosthetic chin implant. She has also had her nose done twice and her cheeks done by other surgeons.

In review of systems by this physician he states, "Review of systems is essentially normal and noncontributory except for that mentioned in the present history." Review of systems includes your muscular-skeletal system.

Most importantly he states in his statement, and please let me finish here, "The patient has full strength in upper and lower extremities, normal sternocleidomastoid and normal trapezius."

Let me just briefly state from the second physician she saw as a result of this unfortunate accident-prone person that she is. The second physician that she saw, "No allergies or traumas. She has had a little cosmetic surgery, but her general history is noncontributory." Furthermore he states, 'Patient has full range of motion." This is a chiropractic orthopedic.

Clearly from the evidence that I just gave to you, you can see that her claim of arm immobility is an absolute lie.

Chairman **Wyden**. We will put that document into the record, Dr. Weissman.

Dr. **Weissman**. Thank you. We have copies for you.

Chairman **Wyden**. Very good.

[Documents may be found in the appendix.]

Chairman **Wyden**. Now Doctor, is it correct that the State of California charged that your care of Ms. Barone was, and I quote, "Grossly negligent, repeatedly negligent, and incompetent," in its February 4, 1988, filing?

Dr. **Weissman**. Yes; that is true. However, this document was filed as a result of Ms. Barone being sent to the board by a plastic surgeon. I would like to read something. As you well know, there is considerable acrimony between plastic and cosmetic surgeons:

After a particularly heated exchange with this plastic surgeon in Santa Monica, he initiated with Barone and with the Board of Medical Quality Assurance what I and other members of the medical, legal, and general public clearly acknowledge is a politically motivated action.

Bear witness to what I just mentioned in terms of the reality of this patient.

As I have explained prior to this point, I did not explain it earlier, but prior to this point of filing of these accusations, that I had an unblemished record with thousands of cases done.

Chairman WYDEN. So it has been established now that in the February 4, 1988, filing that the State of California charged that your care of Ms. Barone was, "Grossly negligent, repeatedly negligent, and incompetent"?

Dr. WEISSMAN. Yes; Mr. Chairman, we have experts on our part, two of whom are board-certified plastic surgeons, stating unequivocally that there was no negligence and that there was no harm done to the patient. What is here, and clearly what was established here, is that a surgeon who feared the emergence of my notoriety, positive notoriety in the community as a successful surgeon, in this turf war, decided that it was his duty to weed out those who are not board-certified by his board. So he took Barone, whose history is clear and you can get further information on that, to the board and those actions were filed.

Chairman WYDEN. Is it correct that the State of California also charged you with "sexual abuse and misconduct" in Ms. Barone's case?

Dr. WEISSMAN. That indeed is true, and it is also a defamatory charge and a lie.

Chairman WYDEN. Do you deny the charges made by the State of California of sexual abuse and misconduct brought by the State regarding Ms. Barone?

Dr. WEISSMAN. Absolutely.

Chairman WYDEN. Did the State also charge that you told Ms. Barone that you would not correct the bad surgical results unless she had sexual intercourse with you?

Dr. WEISSMAN. That is also an absolute lie. You are dealing here with a lady who makes a living out of being a litigant.

Chairman WYDEN. The question was, Doctor, did the State make that charge?

Dr. WEISSMAN. The State made that charge based on testimony given by Barone. Barone, besides having more than one name, is a professional litigant. We have no records that she was ever a professional model. She was convicted on a $50,000 embezzlement and two counts of grand theft. She has two slip and fall accidents pending. She has rear-end collisions pending where I just provided documentation to you that she is a liar.

I also have a letter here from her attorney and from her where she would recant what she said to the board and that she would come clean and tell the truth if I would give her $100,000 cash. I would not give her any money for extortion.

Chairman WYDEN. Doctor, did the State of California charge you with sexually abusing five other patients?

Dr. WEISSMAN. No; there is a charge of sexual misconduct, and they range from hugging a patient who 5 years ago—if you would like I will read a prepared statement that I have on that—5 years ago I operated on a gal. Let me read this to you. I think that you will find it of interest, because it is imperative that I appear here today to clear my record.

Mr. **TANNENBAUM**. Is it the committee's intention to try these charges? They are charges and they are unproven, and there is a presumption of innocence. Mr. Chairman, you know that these charges have not been proven. There are hearing dates set for it, and there is a lot of litigation involved with it. But we are not going to quarrel with you with respect to the fact that we have charges.

Dr. **WEISSMAN**. One of the charges here, I might add, is that I am charged with hugging a patient. Have you ever hugged someone in your office?

Chairman **WYDEN**. Counsel is here to advise his client and not to pose questions.

Dr. **WEISSMAN**. Mr. Wyden, I am asking you, please answer my question, have you ever hugged someone in your office?

Chairman **WYDEN**. Doctor, the Chair asks the questions.

Dr. **WEISSMAN**. I am responding in a question form.

Mr. **TANNENBAUM**. If I could have just a moment.

[Pause.]

Dr. **WEISSMAN**. OK; another charge is that a woman whose breasts we did who had a great result—I am charged with asking her if she had a beautiful body, OK, and hugging a patient 5 years ago. Let me tell you about that patient, if you want to have a little further insight into the bizarre nature of this.

Chairman **WYDEN**. Doctor, we have agreed to your request that you come here and testify.

Dr. **WEISSMAN**. I did not come here to testify.

Chairman **WYDEN**. That is why, given that we are acceding to your request, that I simply want to have clear on the record what the State of California has charged in this matter. We would be happy to take your additional comments at this time.

Dr. **WEISSMAN**. Mr. Wyden, I have responded to the tape and the things that are mentioned in that tape. I am not here today to defend or disprove any of the lies or to disprove here today the accusations. Let me just add to this, that this lady who claims to have been hugged 5 years ago was in an automobile accident and I did her nose as a result of that automobile accident and she got a great result, as did Barone, I might add.

When she sued the insurance company from the people who hit her in the accident, she received $25,000. She turned to me and said that she wanted another $4,000 or she would go to the board. It turns out that my good friend in Santa Monica, that plastic surgeon, went ahead and sent her to the board. She went to the board, because I refused to give her the $4,000, OK. We have letters to that effect as well.

Chairman **WYDEN**. Are you familiar with the charges made by the State of California against you, Dr. Weissman—and I am looking specifically at what the State has said with respect to the sexual misconduct charges—are you familiar with those?

Mr. **TANNENBAUM**. We can stipulate that the doctor is familiar with all of the charges.

Dr. **WEISSMAN**. I am familiar with them. I did not come here today to defend this case.

Chairman **WYDEN**. Let me advise the witness at this point that the witness cannot choose which questions the witness wishes to answer. The witness has come at his request, and the witness will answer the questions.

Dr. **WEISSMAN**. Mr. Wyden, we came here today to respond to what was told by one of your staff members to our attorney that this tape was going to be shown. I have responded to that tape and I believe quite well. I am not here today, although I wish to, I do not think that this is the appropriate forum for me to refute the allegations. What you are witnessing is a person being raised as a scapegoat, if you will, in this battle between the plastic and the cosmetic surgeons.

I have a large practice and it is successful. I took patients away from a plastic surgeon and he was jealous about that. I took a celebrity patient away from him. This, in essence, is how this whole thing was formulated and was started. It is a battle that is wrong and will be addressed in the appropriate forum which I do not think that this is the right one.

Chairman **WYDEN**. Who is this plastic surgeon that you are in this battle with?

Dr. **WEISSMAN**. Steven Hoflin.

Chairman **WYDEN**. The State of California will consider stripping you of your medical license and are pursuing other charges against you at the May 17, 1989, hearing?

Dr. **WEISSMAN**. If it can be proven.

Chairman **WYDEN**. Are there any other comments that you would like to make about the case, the KCET documentary, or the State charges against you?

Dr. **WEISSMAN**. I would like to say that not only did I speak to Ms. Bryant multiple times and indeed clearly spent hours—but let me read a letter sent to KCET-TV on December 7, 1988, to KCET-News and to the attention of Ms. Claudia Bryant regarding Donald Weissman, MD:

> Gentlemen, this office represents Dr. Weissman. You recently aired on two separate occasions a feature news item addressing plastic surgery. The program made specific reference to our client incorrectly stating that Dr. Weissman refused to be interviewed. I have spoken to Claudia Bryant, the producer, on more than one occasion setting forth the facts contradictory to those aired.
>
> Further and more to the point, Dr. Weissman was interviewed by Claudia Bryant. Statements to the contrary impact unfavorably on Dr. Weissman's character and affects his profession. The inference is clear that by refusing to be interviewed that the Doctor has something to fear. The viewer would clearly conclude that Dr. Weissman is guilty of the wrongs depicted.
>
> As you are aware, accusations are presently pending and unproven. As I explained to Ms. Bryant, Dr. Weissman has every reason to believe that he will be completely exonerated, but that exoneration will mean little if irresponsible news stories have, before the hearing, caused him to be found guilty in view of the general public.
>
> The demand is made that you cease and desist from further showing, if any is intended, of the program. In the event that the same should be replayed, that it correctly represent the view of the true facts, including that Dr. Weissman and I were both interviewed as well as his counsel and that those interviews contain denials of any wrongdoing on the part of Dr. Weissman.

This is signed by Alan Segal, an attorney at the time.

Chairman **Wyden**. Doctor, you said that the State has charged you with sexual misconduct in other instances besides Ms. Barone, and you made comments with respect to Ms. Baron's background and suggestions about her veracity.

Do you have any reasons to disbelieve the comments of the others?

Dr. **Weissman**. I had mentioned the fact that I hugged a patient, just like I asked you did you ever hug someone and that you could be charged with misconduct. It is absurd to even consider these charges. What was done here, Mr. Wyden, was to allow the State to try to put a case together.

In that effort to do that, they put in hugging and some other charges that are equally bizarre including telling a patient that she had a beautiful body when indeed she did. They are not coming to me for brain surgery and they are not coming to me for spinal bifida surgery, but they are coming for cosmetic surgery and they are getting a good job.

You are allowing this battle which is being discussed in front of you today to proceed on a small level, if you take the macrocosm to the microcosm and go back to Southern California. I developed a large practice in cosmetic surgery and hence all of this comes down on me because of my visibility and my ability to do good surgery generating a large practice which is feared as a competitor in Los Angeles.

Chairman **Wyden**. At this point in the record, the Chair will insert the charges of the State of California. The Chair wishes to note for the record that it discusses many matters besides allegations of hugging and that nature. Yhat will be put into the record at this point.

[The material referred to may be found in the appendix.]

Chairman **Wyden**. Does the gentleman from Virginia care to ask any questions?

Mr. **Sisisky**. I think that you have covered a good part of it.

You made reference, Dr. Weissman, about your training and all of the papers that you have delivered, and that you spent thousands of hours in an emergency room.

Were you an emergency room physician or were you just doing your training in the emergency room like any other physician?

Dr. **Weissman**. I was supplementing income doing emergency room work.

Mr. **Sisisky**. So you were treating trauma and things like that?

Dr. **Weissman**. Yes; I would like to make one other comment here, Congressman.

[Pause.]

Mr. **Sisisky**. I was not trying to trap the witness.

Mr. **Tannenbaum**. No; we are delighted that you are addressing the issue that we came here to talk about, his competence and the facilities in which he operates. That is why we are here. We are prepared to defend the charges that are now part of the record which are proof of nothing and are just accusations.

Mr. **Sisisky**. Tell me about your hospital credentials.

Dr. **Weissman**. I am fully approved to do all of the surgery that I do in my office, in hospitals, two hospitals.

Mr. **Sisisky**. All of the plastic surgery and reconstructive surgery procedures that you do in your office, you are qualified to do?

Dr. **Weissman**. Yes; I have hospital privileges for that, and I also have malpractice coverage for that. I have all of the qualifications that the gentleman who preceded me mentioned.

I would like to mention a few very interesting facts, Congressman Wyden and Congressman Sisisky. There were four deaths, four deaths, of young teenage people in the Los Angeles area, three of whom I am personally aware of—a third party came to me last week, that resulted from problems encountered in surgery by board-certified plastic surgeons. Those three deaths in the last few years as a result of board-certified plastic surgeons did not, to my knowledge, receive the same attention and notoriety that I have. The problems that we have encountered are absurd. This turf war is being taken too far.

Mr. **Sisisky**. I am glad that you raised that point. There is a difference, Dr. Weissman. The American Board of Cosmetic Surgery, and I will ask them to delineate and detail this again, does not solicit patients for surgery by telling them that when the surgery is done that they will "be a knockout." That is the real difference in my opinion. You are soliciting and you are operating on people, you encourage them to have the surgery, and that is the difference. Certainly everybody knows that nobody is perfect. I do not care if you are board-certified or anything else, but I am concerned about soliciting patients and there is where the difference is.

Dr. **Weissman**. Mr. Sisisky, I would submit to you that if you look at that board over there that the vast majority—can I stand up and point them out to you directly?—that the vast majority of those are from board-certified plastic surgeons, not cosmetic surgeons. The vast majority of that advertising that you are bearing witness to right now is from board-certified plastic surgeons and not cosmetic surgeons. So that question is better addressed, the solicitation.

Mr. **Sisisky**. About fifty-fifty.

Dr. **Weissman**. I would like to go up and count fifty-fifty.

Mr. **Tannenbaum**. We will accept the fifty-fifty.

Mr. **Sisisky**. OK.

Dr. **Weissman**. Let me give you an interesting quote, if you want to talk about fifty-fifty. Dr. Mark Gorney was here and he says that he trains people and he is on the board of the insurance company. His insurance company sent me a newsletter, from the Doctors Insurance Co., stating—and I am paraphrasing but the intent is actual and what I am saying to you is very correct—that there is no difference between the number of lawsuits filed or the outcome or resolution of those lawsuits between board-certified plastic surgeons and other surgeons.

I submit to you today, Congressman, that my presence here, and I did not expect to get into the entire spectrum of this, but we were informed prior to my coming here that this might happen, that we might enlarge beyond the scope of why we are here.

Mr. **Sisisky**. I am just going by what this is.

Dr. **Weissman**. Yes; OK. It is 50 percent.

Mr. **Sisisky**. That is fine. You are doing well. I feel like I am watching General Hospital today. I do not care if you are board-certified or not. You know, the issue really is these ads, and what really bothers me and concerns me is physicians are doing advertisements like this.

Dr. **Weissman**. I respect that.

Mr. **Sisisky**. I was going to ask the other doctors that question. But I am delighted that you are here, and I think that you have done what an American citizen has the ability to do, and I am delighted that you are here.

Dr. **Weissman**. Thank you very much, Congressman. I am only sorry that I have come here to fight what are outrageous actions. Let me just read one last thing to you. My regret is not being here, but my regret is the fact that I had to be here to defend myself. I have an excellent record, surgical record. I have an excellent record as a citizen.

Mr. Chairman, I just want to read one thing to you which I think sums up my feelings. On a personal note since having been caught in this crossfire and as a result of the tactics used in investigating me, I am faced with a battle to preserve my licence and to practice medicine. This is a vocation to which I have devoted years of training. It is the livelihood for my wife, my two young sons, and my family. Despite of having one prior lawsuit against me prior to this board investigation and thousands of positive results, the cost of my annual malpractice premium has gone from $26,000 to $110,000. The cost of my defense has depleted savings and has placed me and my family in severe economic and emotional strain. I frankly cannot believe that this is happening to us in America where constitutional civil liberties are the bounty of our expression. Where one is presumed innocent, I have been judged guilty prior to and without any substantiation of fact, have been tainted and falsely accused of misconduct without due process or any semblance of legal standards of jurisdiction.

This type of rampant and vindictive persecution by a State agency in concert with a special interest group cannot be tolerated or allowed to continue. We all have the moral obligation and the civic responsibility to stop and correct this form of unbridled bureaucratic abuse in destroying a competent physician and surgeon.

I hope that my appearance here today has helped clarify some of these misconceptions created about me and other cosmetic surgeons, and that you might intercede in this conflict to protect other surgeons from the type of practices that have been directed against me. This is an outrage.

Chairman **Wyden**. Doctor, let me ask you just a couple of additional questions.

There have been malpractice suits filed against you?

Dr. **Weissman**. Yes; there have.

Chairman **Wyden**. How many?

Dr. **Weissman**. Five, all I might add stemming from the result of these suggestive manipulative and promulgating techniques on the part of this person. I certainly hope that in the appropriate forum that the realities of this situation are heard and discussed so that I can be cleared.

Chairman **Wyden**. Let me ask you one other question to go back to a point that I think is important. You said that the State had charged you with sexually abusing five other patients, and made comments about Ms. Barone relating to her background and her veracity.

I would like to ask you again, is there anything specific that you can tell us which would cause us to have reason to doubt the veracity of any of the other complainants?

Dr. **WEISSMAN**. Mr. Wyden, the answer is yes. I would in my heart and in my soul love to address that question more fully. I would be more than happy to clear myself as I am sure I will be when I do address those specific questions. I do not think that this is the appropriate forum.

Chairman **WYDEN**. Dr. Weissman, it is not possible to appear to answer some questions rather that others.

Do you wish to take with respect to this point the Fifth Amendment?

Mr. **TANNENBAUM**. No; he is not going to take the Fifth Amendment, Mr. Chairman. What he is saying is that you put in the record the formal charges and he can respond, and there are a lot of issues with respect to impeachment as you know well from your experience. This is not the time to go through that. He is saying that the answer is yes, but that this is not the opportunity to really go through it.

Dr. **WEISSMAN**. It is sort of like giving away your defense when you are being attacked. I would rather give my defense in full, and completely, and with clarity, and with clearance of these charges at that time. This is not the time to discuss this case any further. I ask you to please understand that.

Chairman **WYDEN**. You said to this subcommittee earlier that with respect to others that, it was just a matter of hugging a patient.

Dr. **WEISSMAN**. I did not say that. I said that there were others and perhaps even wilder comments, and those will be refuted as well. This is not the appropriate forum for that. Our coming here today was specifically to address what was on that tape, and I think that we did it well. I think that you understand now what I am facing. I am facing a felon with two slip and fall accidents with a history of rear-end collision with a letter that I have which I would submit to you in camera of extortion, that she would tell the truth and come clean if I gave her $100,000.

I have other letters from other people. There are other letters that we have and I do not think that this is the appropriate forum, and I would be more than happy in camera to show you those letters.

Chairman **WYDEN**. Doctor, just for the record, tell us how many others have charged you?

Dr. **WEISSMAN**. Five.

Chairman **WYDEN**. Five others?

Dr. **WEISSMAN**. Five.

Chairman **WYDEN**. Besides Ms. Barone?

Dr. **WEISSMAN**. Yes.

Chairman **WYDEN**. All right.

Dr. **WEISSMAN**. The hugging is one, the beautiful body is another one. The do you love me is another one, and it was not done with the beat of a song either.

Chairman Wyden. The charges made by the State of California consists of quite a bit more than that.

Dr. Weissman. Including using my name as the Weissman Institute.

Chairman Wyden. We will put that into the record. I appreciate having some clarity of the point that there are five others according to the charges. This subcommittee is pleased that we could accede to your request that you come here today. If you have nothing further to add, I am going to recognize minority counsel for any questions that he might have.

Mr. Russinoff. I really do not have any questions. Thank you, Mr. Chairman.

Dr. Weissman. Thank you.

Chairman Wyden. Does the witness have anything else that he would like to add?

Mr. Tannenbaum. The witness would like to thank this committee for the opportunity to come forward, and I join in that as well. Thank you very much.

Chairman Wyden. The witness is excused.

At this time, the subcommittee Chair notes that we have three panels left to go. We will take a break and reconvene at 2 p.m. this afternoon for the remaining three panels.

[Whereupon, at 1:23 p.m., the subcommittee recessed, to reconvene at 2 p.m., this same day.]

The committee met, pursuant to notice, at 2:00 p.m. in room 2359-A, Rayburn House Office Building, Hon. Ron Wyden, presiding.

Chairman Wyden. The subcommittee will come to order. We are pleased to have as our next panel the American Academy of Cosmetic Surgery. Gentlemen, we welcome you. Dr. Richard Caleel, president, Chicago, IL; Dr. Julius Newman, Philadelphia, PA; Dr. Richard Webster, Brookline, MA; Dr. Bruce Chrisman, Honolulu, HI; and Dr. E. Antonio Mangubat, Silver Spring, MD.

Gentlemen, it is the practice of our subcommittee to swear all of the witnesses.

Do any of you gentlemen have any objection to being sworn today?

[No response.]

Chairman Wyden. Please rise and raise your right hand.

[Whereupon, the witnesses were duly sworn.]

Chairman Wyden. Gentlemen, we are going to make a copy of your prepared remarks a part of the hearing record in their entirety. If you could summarize your principal concerns, that would be helpful in the interests of time. I am going to have to restrict our witnesses to 5 minutes each at this point and be very vigorous about enforcing the 5-minute rule. Why do we not begin with you, Dr. Caleel.

Dr. Caleel. Good afternoon. Mr. Wyden, I would like to change the order of presentation slightly and have Dr. Webster begin, who I will follow.

Chairman Wyden. Without objection, so ordered.

Dr. Webster.

TESTIMONY OF DR. RICHARD C. WEBSTER ON BEHALF OF AMERICAN BOARD OF COSMETIC SURGERY, AMERICAN ACADEMY OF COSMETIC SURGERY, AND AMERICAN SOCIETY OF LIPOSUCTION SURGERY

Dr. **WEBSTER**. Good afternoon, Mr. Chairman, and members of the subcommittee. My name is Dr. Richard Webster, and I am a retired cosmetic surgeon currently acting as a professor of otolaryngology and cosmetic surgery at the Boston University Medical School. I am a lecturer at Harvard Medical School, and I am a board-certified plastic surgeon, formerly chief of plastic surgery at Melrose Wakefield Hospital.

I am a former president of the American Academy of Cosmetic Surgery, as well as of the American Academy of Facial Plastic and Reconstructive Surgery, and the American Cleft Palate Association. It is in my current capacity as an advisor to the American Board of Cosmetic Surgery that I shall address you today.

Each field can show bad results or disasters coming from practitioners of the other competing fields. Any intelligent observer can draw only one basic conclusion from the bad results coming from all of the groups, that today's system is not good enough for the consumers or the practioners.

Let the unfortunate results recounted here, and others like them that could be shown from each of the disciplines, lead to positive changes in the system that has permitted the suffering of these poor patients to take place.

In the evolution of specialties, it once was thought necessary to certify specialists in entire fields. However, certification in an entire field as provided today does not and cannot answer the key question of the consumer—is Dr. Smith adequately trained, knowledgeable, and experienced—this is the important part of it—in the particular operation that I, the consumer, want to have performed?

I passed the examinations to become board certified in plastic surgery 35 years ago. Not one operation, as I have performed it in the last 10 years, did I learn during the required years enabling me to get my boards. Still the board certificate permitted me as a specialist to get on the staffs of many hospitals, and entitled me to be credentialed to do essentially every procedure listed in the huge fields of plastic and maxillofacial surgery.

Until I retired I automatically was permitted to renew my privileges to do all of these procedures. Now, just because organized medicine has endorsed the system that made this possible does not make the system right. I know and those planning for the public good should know, in spite of any contrary claims that not one individual labeling himself a specialist in an entire field can have the volume of patients undergoing all of the procedures in that field to be expert in each and all of the operations.

It is a fundamental that every field is made of a limited number of specific procedures. For the future, it is imperative that those providing peer review or certification do it procedure by procedure rather than by giving approval for an entire field.

At first our American Board of Cosmetic Surgery tested applicants on the entire field of cosmetic surgery. But we feel that the time has come for us to do what we can do to answer that key consumer question, is Dr. Smith adequately trained, knowledgeable, and experienced in that particular operation that I want? In its next examination, our board will require the applicant to show that he is sufficiently trained and educated to meet peer-decided requirements as to core and general knowledge and total volume of cosmetic operations performed.

Further and most importantly, it will test for a much more detailed knowledge of the specific cosmetic procedures for which the applicant wishes to get peer certification. This may require submission of a certain number of consecutive case reports dealing with that particular procedure or dealing with a relatively small cluster of related procedures. It will require a sworn statement as to the numbers of those procedures that the individual has observed and performed.

Fortunately in cosmetic surgery, the surgeon's volume of patients undergoing a particular procedure is more likely than in most other fields to have a relationship to competency. When it comes to improvement in appearance, the patients are often as capable of judging the quality of the result as are the surgeons themselves. In most cosmetic practices, the patients come largely from other patients whose results they have seen. Therefore volume or experience can be of real help in peer review.

We are very interested in seeing that representatives of each of the groups represented here today come together for the purpose of establishing minimum requirements for each of the cosmetic procedures. These individuals can then assist in getting their existing boards to certify the specific procedures that concern us as cosmetic surgeons. However, we at the academy will do it alone if need be or with other boards. The ultimate goal is to protect the public first, the field second, and finally the practitioners, but all three are important.

Last, let me say that our groups firmly believe that this subcommittee has quite legitimately raised these questions, and that they have a role to play in seeing that the questions are answered and the problems resolved.

We thank you for inviting us to testify today, and we look forward to working with you and the subcommittee staff along with our fellow practitioners in the future.

Now Mr. Chairman, I would like to respond to a personal attack made on me by the prior group. May I quickly respond?

Chairman **Wyden**. Please.

Dr. **Webster**. Dr. Norman Cole made a quote from an article that I had written and I want to put that in context. This had to do with what we consider in the cosmetic group a restriction on us imposed by the plastic surgeons who will not allow our advertisements to appear in their journals and their publications. That is what we were addressing in this particular article. We feel that any journal should accept on an equal footing ads from competing groups for the educational dollar. We compete for that just as the plastic surgeons do, but we have been restricted in not being able to do that.

So what I said there was that our American system is predicated upon unfettered competition, as unfettered competition as possible, and the right of an individual or an organization to compete fairly is a precious one indeed. We must insist that those who have limited or usurped our rights in the respect just described, cease such actions. We feel strongly about that, sir. But that had nothing to do with the actual care of patients which was the incorrect inference made by Dr. Cole about me.

[Dr. Webster's statement may be found in the appendix.]

Chairman WYDEN. We appreciate your testimony, Dr. Webster, and your additional remarks.

Dr. Caleel, what would be your preference about your associates? Is there any order that you would like to go with today?

Dr. CALEEL. I believe that the rest of the order will be fairly as published. I will be second, Dr. Newman, Dr. Chrisman, and then Dr. Mangubat.

Chairman WYDEN. So you would go second, Dr. Newman would go third, and then you would like to have Dr. Chrisman go fourth?

Dr. CALEEL. That is correct.

Chairman WYDEN. Then Dr. Mangubat?

Dr. CALEEL. Correct.

Chairman WYDEN. Very good.

TESTIMONY OF DR. RICHARD T. CALEEL, PRESIDENT, AMERICAN ACADEMY OF COSMETIC SURGERY; PRESIDENT, AMERICAN SOCIETY OF LIPOSUCTION SURGERY, INC.

Dr. CALEEL. Good afternoon, Mr. Chairman, and members of the subcommittee. My name is Dr. Richard T. Caleel, and I am a professor of surgery and a cosmetic surgeon. I am here today to speak to you in my capacity as president of the American Academy of Cosmetic Surgery and the American Society of Liposuction Surgery.

I would like to delineate the mission and goals of our organizations and the question of the American Board of Cosmetic Surgery will be addressed by its president, Dr. Julius Newman.

The mission of the American Academy of Cosmetic Surgery and the American Society of Liposuction Surgery is to provide an educational organization to serve the needs of health care professionals who have an interest in cosmetic surgical or dental procedures. These organizations are first and foremost for the purpose of education.

Through the academy and the society, world congresses are sponsored, meetings and workshops are conducted, and publications are produced to enhance our members' knowledge of cosmetic surgical techniques and concepts. As officers of an educational organization, we open these meetings to all who are licensed to provide cosmetic surgical care. It is our firm belief that increased knowledge will benefit all of us and our patients. Therefore we make no attempt to limit access to our educational functions.

In order to further illustrate our commitment to the education of our membership, I think that it may be helpful to outline the goals of the academy and the society as they currently exist.

First, the academy and the society will maintain a multidisciplinary educational organization open to all practitioners licensed to provide cosmetic surgical and dental procedures to the public.

Second, the academy and the society will assist in providing clinical and educational patient care environments to support the study, practice, and research of cosmetic surgery at the highest quality level expected by the public.

Third, we will continue to develop programs in health education and consumer information services that will improve the effectiveness of enhancing the health care of the public.

Fourth, we will continue to encourage an atmosphere of growth and support for the continuing medical education programs of our membership.

Fifth, we will continue to maintain our commitment to educational programs for allied health science professionals.

Sixth, the academy and the society will continue to support accreditation of outpatient surgical facilities. In particular, the Accreditation Associations for Ambulatory Health Care which is nationally recognized as an accreditation organization.

Seventh, we will continue to encourage truth in advertising in order to protect the consumer.

Eighth, we will continue to actively support the American Board of Cosmetic Surgery and its certification process.

Ninth, the academy and the society will continue to support and encourage the peer review programs of the American Board of Cosmetic Surgery and other appropriate organizations.

Tenth and last, we will continue to solicit and encourage interorganizational cooperation with related groups in order to foster the continued growth of our specialty for the benefit of its practitioners and the consumer public.

Those of us in the American Academy of Cosmetic Surgery take great pride in the fact that the Accreditation Council for Continuing Medical Education granted accreditation of our organization for the maximum period allowed a new applicant following their first review of our programs. In addition our publication, the American Journal of Cosmetic Surgery, is enjoying continued growth and recognition for its contributions to the field of cosmetic surgery.

The academy strongly supports truth in advertising by all physicians regardless of training, background, or professional group affiliation. We object to any interference with the ability of an appropriately licensed physician to continue his medical education and to obtain appropriate hospital privileges in malpractice coverage in order to practice. We support the American Medical Association's stand that privileges should be granted on the basis of training and experience and not certification.

The academy and the society recognize that cosmetic surgery has become an art and specialty of its own. As the public demands higher aesthetic and technical standards for these services, the health care providers have pursued advanced training in their original areas of specialization. We believe that no particular group of health care providers has a monopoly on the provision of these services, nor is any group completely free of individuals who abuse them.

We also believe that no group has a monopoly on education, nor does any one group have the right to exclude other licensed professionals from obtaining a continuing medical educational experience.

At the academy it is our contention that one of the effective weapons against unsatisfactory results is education. Since no single training discipline can adequately represent all of those who have chosen to specialize in cosmetic surgery and dentistry, the American Academy of Cosmetic Surgery and the American Society of Liposuction Surgery act as a necessary and important voice for these providers.

With that in mind, we shall continue to support the cosmetic surgery information service and its programs in cooperation with the American Board of Cosmetic Surgery in order to offer the public an appropriate avenue for information regarding cosmetic procedures and certified cosmetic surgeons.

Chairman **Wyden**. Doctor, excuse me. We have had you go almost 10 minutes I think at this point.

Dr. **Caleel**. Thank you, Mr. Chairman. We appreciate the opportunity to be here today.

Chairman **Wyden**. Is there anything else that you would like to conclude with?

Dr. **Caleel**. I will conclude at this time and reserve further comments for questions. Thank you.

[Dr. Caleel's statement may be found in the appendix.]

Chairman **Wyden**. Very good. Thank you.

Our next witness, Dr. Julius Newman.

TESTIMONY OF DR. JULIUS NEWMAN, PRESIDENT, AMERICAN BOARD OF COSMETIC SURGERY, PHILADELPHIA, PA

Dr. **Newman**. I am Dr. Julius Newman, and I am president of the American Board of Cosmetic Surgery and chairman of the Department of Cosmetic Surgery at the Graduate Hospital in Philadelphia.

Mr. Chairman, I have one comment before I start my presentation. I would like to clear up a false statement that I think was uncalled for. That is the statement of Joyce Palso. On the bottom of the first page of her statement, "I looked on the doctor's credentials and noticed that he had listed that he was a member of the Board of Cosmetic Surgeons." Not only did Joyce Palso make that statement, but the members of the Plastic and Reconstructive Committee who are speaking here made the similar statement that he was a board-certified cosmetic surgeon.

Before this committee and all of the guests, Dr. Dean who performed the surgery on that patient is not and never was board certified by the American Board of Cosmetic Surgery. That is a falsity.

I will go into my presentation at this time. In 1979, a group of cosmetic surgeons decided there was the need for a new specialty, namely cosmetic surgery. It was our goal to have this new specialty involve surgeons from various surgical specialties. The first group of doctors sat for this examination in Los Angeles, CA, in January 1982.

The plastic and reconstructive surgeons publicly took the stand that cosmetic surgical training given in their 2-year residency program was sufficient. They further stated that they did not see the need for a separate specialty. But in 1982, three well-known and respected plastic and reconstructive surgeons incorporated their own board of Cosmetic Plastic Surgery. Legally, they were unable to have their own board of cosmetic surgery and they changed their tune stating that it was their position that there was now no need for a special board of cosmetic surgery.

The false message that they promoted and continue to promote to the public is that their program is 7 years in training, but in reality only 2 years are involved with a plastic and reconstructive surgery residency. In 2 years, their residents have to strive for proficiency in hand surgery, burn surgery, head and neck cancer surgery, transsexual surgery, maxillofacial surgery, hair lip and cleft palate surgery, skin grafting, trauma surgery, skin surgery, craniofacial surgery, and cosmetic surgery including liposuction.

Our position is that board certification in plastic and reconstructive surgery does not necessarily mean that the doctors are experienced and competent in cosmetic surgery. To show that this is true in the issue of the Annals of Plastic Surgery this past month, there is an article so stating of their weaknesses in the area of cosmetic surgery. Almost 50 years ago when a group of surgeons decided to form a board of plastic and reconstructive surgery, they used the same methods that we are employing, that is gathering surgeons from various surgical specialties who had practices with an emphasis in reconstructive surgery, and these surgeons were grandfathered in as board certified.

Never in the history of medicine has any one group attacked another group in such a vicious manner through the mass media as the plastic surgeons have attacked the cosmetic surgeons.

We take great pride in the establishment and growth of our board. Our written and oral examinations are established to accept and pass only those doctors with the finest credentials. We are proud of our record, and we take umbrage with the false statements made by the plastic surgeons that ours is a diploma mill.

The rate of passing of those taking the boards in cosmetic surgery is approximately 60 percent, and our requirements for admission to the board set standards so that only those doctors truly qualified will be accepted.

Despite charges to the contrary, candidates who apply for board certification in cosmetic surgery must have primary board certification in any one of the following surgical specialties that are approved by the American Board of Medical Specialists, such as otolaryngology/head and neck surgery, plastic and reconstructive surgery, and gynecology. That was also accepted by the plastic people as a prerequisite.

They state that 3 years is all that is necessary in general surgery prior, and ours is 5 years. When we inaugurated our board examination, we started with a fellowship program. We now have five in cosmetic surgery and three in dermatologic surgery. Beginning in July 1990, we will have the first 2-year residency program in cosmetic surgery at two facilities. We feel that our programs will be equal to and we feel better in the area of cosmetic surgery. If you look at our exhibits, you will see the comprehensiveness of our residency program that will be started.

Surgeons who enter our residency program will have to have a prior residency in a major surgical specialty and not general practice, cardiology, and so forth as the plastic surgeons have stated.

We realize most important that there is a need now for subcertification. It is with pride that I can report to this subcommittee that beginning with our board examination in January 1990, that we will certify doctors in cosmetic surgery and we will subcertify doctors in any one of a combination of the following areas. In our packet, you will see the eight areas in which we will subcertify doctors which will mean that patients coming to that doctor's office will know exactly what area of expertise he is in.

We have made far-reaching decisions. It is important to understand that in cosmetic surgery that there is a problem with some doctors not having an operating facility in a hospital. Before a doctor can take his boards in cosmetic surgery, if he has no hospital privileges, we will send a team of two board-certified cosmetic surgeons to his facility to evaluate it to see what surgery he is doing and to check his record keeping. We challenge any organization to establish such a program to evaluate doctors' facilities, and we are going to do that.

I give you my personal commitment as president of the American Board of Cosmetic Surgery to do everything in my power to establish this board as a premier board for cosmetic surgeons both in certification and subcertification.

We are also developing the first program of peer review of any major surgical specialty, not only when the doctor is under the gun, but we will every 5 years evaluate his practice and come up with guidelines of what that doctor is doing.

I wholeheartedly agree with this committee that the consumer must be protected, and that we should disband the outdated concept of caveat emptor, or buyer beware. Our group is dedicated to the specialty of cosmetic surgery as an accepted and well-recognized specialty. The American Board of Cosmetic Surgery needs protection from the Society of Plastic and Reconstructive Surgeons, and they refrain from their continued smear campaign to discredit our organization. I hope that this committee will realize the necessity for this specialty of cosmetic surgery. Thank you very much.

[Dr. Newman's statement may be found in the appendix.]

Chairman **Wyden**. Doctor Newman, thank you very much. We will have some questions in a moment.

Dr. Chrisman. Again, let me say that now I am going to have to really stick to the 5-minute rule. Otherwise, we will be here to breakfast tomorrow.

TESTIMONY OF DR. BRUCE B. CHRISMAN, SECTION HEAD FOR DERMATOLOGY, AMERICAN ACADEMY OF COSMETIC SURGERY, HONOLULU, HI

Dr. **Chrisman**. Thank you, Mr. Chairman, for allowing me to testify. My original specialty was dermatology and I am very well aware that you and some of the other committee members have questioned the ability of dermatologists to do cosmetic surgery and their rightful place in the field of cosmetic surgery. I am a section head for dermatology of the American Academy of Cosmetic Surgery. There are three such heads—facial plastic surgery, plastic surgery, and dermatology.

I am also on the advisory board of the American Society for Liposuction Surgery, a major affiliate of the American Academy of Cosmetic Surgery. I am also a board examiner of the American Board of Cosmetic Surgery, one of the several dermatologic surgeons who are part of that board along with other specialists. So I have examined people from various specialties including my own as they go through the boards and have seen the failures and powers of those people that apply, all of whom have significant credentials even before they are allowed to be there.

I have come up through the ranks from someone who was a surgically oriented dermatologist during my residency to someone who did a little more surgery and a little more surgery and became more and more interested in it. I was prompted to move further in it by patients of mine who liked the surgery that I was doing. Because I am very artistic, I gradually moved into a new era which was the era of post-graduate training, which as I am sure you know, is very popular all across the country amongst all of the specialties, particularly those who do cosmetic surgery because so much of it is ever changing and so much of it is taught after residency.

In my very strong opinion, not any of the current specialties—plastic surgery, facial plastic surgery, and dermatology—who are the main providers of cosmetic surgery in this country, provide adequate training at this time in cosmetic surgery. There is simply too much to be learned in those residencies in other things. Cosmetic surgery is relegated to last in line, and oftentimes the chairman or other staffs of those residency programs are not the world's leaders in cosmetic surgery. So the training in some cases is inadequate.

The post-graduate training is superb. I can testify to that from personal experience. Because when you go to the seminars, they are chaired by people who have vast experience in procedures, particularly special procedures which one might wish to learn. The amount of information and experience with those procedures and complications in care is absolutely exemplary in that post-graduate training. Over a number of years, I have gradually changed my specialty to that of cosmetic surgery, and that is virtually all that I do.

I have observed some things that have been mentioned today a number of times, and that is that my colleagues in plastic surgery claim that everyone should have malpractice insurance and that everyone should have hospital privileges, while at the same time they do everything in their power to keep their competitors from having such insurance and such privileges.

Dr. Gorney mentioned that he is on the board of advisors of one of the biggest insurance companies in the country. That is the case in many insurance companies. Guess what they are advised, that the people who do other procedures in cosmetic surgery other than themselves should pay the same rates as them even if they only do one procedure, effectively financially forcing those other competitors out of the marketplace who do not make anywhere the income that they do.

The hospitals across this country are told by plastic surgeons over and over again, and I have witnessed this personally from my colleagues in my own State and from colleagues elsewhere over and over and over again, that these people are competitors and they are not qualified and they cannot do it, we are the best, we are the only ones who should be allowed to do it.

The credentials committees in our hospitals are not objective hospital administrators. They are doctors who are often the close surgical colleagues of these plastic surgeons and are very loathe to let newcomers into their operating rooms, and very loathe to objectively examine the credentials of persons such as myself and many others.

Frankly, I am really, really tired of going to meetings and hearing exemplary physicians with exemplary long-term records, professorships, writings and so on, tell me sadly of the difficulties that they have had in getting hospital privileges, whereas as Dr. Webster has outlined, plastic surgeons across the country routinely march into hospitals and because of the long-time position of their specialty are simply given privileges in cosmetic surgery and many other procedures with virtually no credentialing at all.

I think that the message that I would personally bring to this committee to sum up is that the number of man-hours that I have spent defending myself against demeaning libel, slander, maliciously oriented lawsuit efforts, and difficulties in getting hospital privileges, and difficulties about insurance, have all come from one specialty seeking to demean and restrict its competitors, namely plastic and reconstructive surgery. I have spent literally hundreds of hours in that regard that I could have better spent on training and on teaching.

If you multiply my case by the approximately 6,000 cosmetic surgeons who compete with the plastic surgeons, I would ask you to compute how many thousands of physician hours could have been spent on the care of patients in this country.

I beg you and I urge you to get the FTC to investigate this on a national basis. They will uncover hundreds of cases of restraint of trade in this country in the field of cosmetic surgery very legitimate, very ethical doctors who have been restrained from trade and the public has been restricted from their services by the efforts of one specialty and a number of its members. Thank you for allowing me to testify.

[Dr. Chrisman's statement may be found in the appendix.]

Chairman WYDEN. Doctor, thank you very much. We will have some questions in a moment.

Dr. Mangubat.

TESTIMONY OF DR. E. ANTONIO MANGUBAT, SILVER SPRING, MD

Dr. MANGUBAT. Thank you, Mr. Chairman, members of the subcommittee, fellow surgeons, ladies, and gentlemen, may I state for the record that I speak not as a representative of the American Academy of Cosmetic Surgery, but rather as a young surgeon who has practiced for 2 years here in the Washington area.

I am, however, a full fellow of this organization and I fully support its goals to maintain quality in cosmetic surgery. Because my practice is relatively young, I have a somewhat skewed if not naive view of the politics of cosmetic surgery. However, I would like to thank the subcommittee for inviting me to tell my story and I hope that my testimony will be of value to the subcommittee's efforts to improve the safety, the art, and practice of cosmetic surgery.

Let me begin by describing professional background, which is both typical and unusual for surgeons practicing cosmetic surgery today. Typical, in that I studied the art of cosmetic surgery at the side of an experienced and well-known master of the craft. Unusual, in that my prior surgical experience, although extensive, was not one of the common surgical subspecialties that spawn the majority of cosmetic surgeons today. I spent 2 years at the University of Kentucky doing a general surgery residency during which time I obtained a broad and extensive operative experience. As the primary operating surgeon, I performed 356 surgical procedures which include 46 gall bladder operations, 30 breast operations, 10 of which were radical or modified radical mastectomies, 28 resections of the large bowel and 13 gastric bypasses. I performed a total of 157 intraabdominal operations. As the first assisting surgeon, I performed approximately 200 more procedures.

I developed an interest in pediatric surgery and trauma and elected to do a 1-year research fellowship in pediatric trauma at the Children's Hospital National Medical Center here in Washington, DC.

During my fellowship, I coauthored an educational grant which was funded and allowed me to stay on in the Nation's Capitol. As a result, I was able to author several scientific papers and participate in the creation of four documentary and training films. I made significant contributions to the interhospital pediatric transfer protocols for the State of Maryland and created a computerized trauma data management system which is currently recognized as the best system available today.

Also, this led to my certification as an instructor and course director in advanced trauma life support and advanced cardiac life support curricula sponsored by the American College of Surgeons and the American Heart Association, respectively.

As a result, I had the opportunity to teach other physicians and surgeons the essentials of emergency trauma and cardiac care.

Over time, my interest, my intense interest in emergency care was tempered by the all too common conflict of a large time commitment to my work and my desire to be with my family. I have devoted most of my career to being precise and meticulous in my desire to find a career path that would provide me with the ability to be a surgeon which I enjoy most, yet maintain control over my life which is inherently difficult to do in any endeavor of emergency medicine.

Cosmetic surgery appeared to fit this mold. It was elective and could be scheduled. Patients sought me out for my services as opposed to being cast into my care by fate and I would be able to practice my first passion: surgery.

After all, I've already honed my basic surgical skills on operative procedures that most surgeons would consider to be of much greater magnitude but of no less importance than the most complex cosmetic operations.

From this point, like most surgeons who seek to practice cosmetic surgery, I sought out the experts in the field and voraciously read all the literature and textbooks pertinent to cosmetic surgery that I could obtain. I attended numerous excellent educational seminars and meetings of the American Academy of Cosmetic Surgery of which I am currently a full fellow and the American Academy of Facial Plastic and Reconstructive Surgery. The outstanding curricula of these organizations allowed me to gain a much broader exposure to cosmetic surgical techniques not available elsewhere.

I reviewed in detail and on numerous occasions the video tapes of many of the world's best surgeons performing the procedures of their respective expertise including Drs. Richard Webster, Thomas Weiss, Jack Anderson, and Gaylon McCollough, only to name a few. I have performed many of these procedures on cadaver preparations which in many ways is superior to live patients because once the procedure is completed the underlying anatomy and dynamics can be further dissected in more detail allowing a significantly better understanding of the operation.

As fate would have it, I was introduced to Dr. Richard C. Webster by my father-in-law, Dr. Milton Henderson, who is Dr. Webster's personal surgeon. Dr. Webster took me under his wing and I was able to spend a considerable amount of time training at the side of one of the best recognized and well respected cosmetic surgeons in the world.

In August 1986, I began assisting Dr. Roger Anderson, a facial plastic surgeon in this area who trained with Dr. Julius Newman and obtained further practical experience in cosmetic surgery. Then in April 1987, I opened my practice and my own out-patient facility which was specifically built for practicing the art of cosmetic surgery. I have now been in practice 2 years during which time I have operated on 246 patients, performing 767 procedures. Thirty-four of those patients returned for additional surgery, which is 14 percent. Eight procedures, 1.04 percent were revisions of my previous work. No patients have ever required hospital admission. No malpractice suits have ever been filed or are pending against me and there have been no complaints filed with the Maryland Board of Medical Examiners.

A philosophy I have adopted which pervades every aspect of my practice is to educate patients, not to sell surgery. I stress this concept to my entire staff and insist that every question is to be taken seriously and that every patient is to be treated with respect. I carry out my duty as a surgeon to inform the patient of the options, the expected results and I make a special effort to stress the potential risks and complications. Each patient is offered the opportunity to inspect my before and after photographs. I make it a liberal policy to offer to my perspective patients contact with many of my past patients so that they may privately and openly discuss their feelings about their surgery.

Should a patient develop a problem that is beyond my expertise, I have no hesitation to refer him or her to another surgeon with greater experience with that condition. Should a patient be a poor candidate for cosmetic surgery, I have no hesitation in referring him, turning him away and not operating on him purely in his best interest. If a patient requests a list of surgeons who do the procedure that we are discussing, I do so gladly and encourage them to visit.

Chairman **Wyden**. Doctor, we are 8 minutes at this point in terms of your testimony. Could you wrap it up with a couple of quick comments?

Dr. **Mangubat**. I certainly can. Let me briefly address the issue of advertising as this has been a major topic here and how it applies to my practice. As you are aware, the use of advertisements in the medical profession is currently an accepted way to attract new patients. Some may feel, however, that despite its acceptance, advertising of medical procedures suggests questionable judgment at best, while at worst, in the case of deceptive advertising, may indicate unethical behavior.

Although I cannot comment on the actions of others in my field, I can say from my personal perspective the decision to advertise reflects a very practical need. That is to let prospective patients know I exist.

As a young surgeon with a new practice, I do not have the luxury of a large patient base for referrals. As a result, I chose advertising as a way to announce to the public my surgical practice is open for business. I advertise in print and on radio. I feel my ads are accurate and informative with educational value. My advertisements make no guarantee of success, nor do they in any way attempt to give patients unreasonable expectations. They simply describe cosmetic procedures and encourage interested patients to call for consultation.

In closing, I share the subcommittee's commitment to excellence. I feel it is the responsibility of each practitioner to bring him or herself up to the current standard of care by regularly attending educational seminars and meetings. Post-graduate education in this rapidly changing field is an absolute necessity. Throughout my career, I will seek additional training on an ongoing basis, enhancing my skills so that I can continue to provide quality care. It is my sincere wish that my testimony will be of value to the subcommittee in its worthwhile task of assessing and improving the safety and quality of cosmetic surgery services rendered to the public. I would like to thank the subcommittee for this opportunity to testify. Thank you, Mr. Chairman.

[Dr. Mangubat's statement may be found in the appendix.]

Chairman **Wyden**. Doctor, thank you and let me thank all of you. This has been a long hearing and you have been very patient.

Dr. Caleel, let me begin with you. You are the president of the association. Let me start, initially, to see if I can get us out of some of the debate about turf and one group versus another. Is it your view that, generally, in the cosmetic surgery field, not to take any one discipline or any one profession, that generally in the field the number of quacks and charlatans is growing and growing along the lines that this subcommittee has been told about?

Dr. **Caleel**. I believe that there are individuals who abuse the privilege to practice medicine. I believe that in the current setting that there are a significant number of them in the field of cosmetic or plastic surgery.

Chairman **Wyden**. Do you feel that the problem of deceptive or misleading advertising is as significant as we have been told about today?

Dr. Caleel. I believe that in advertising in general and, of course, specifically in this area, that there again are a number of individuals who abuse the privilege. I believe that all of these organizations together with the Government should work together to try to minimize and, hopefully, although probably not possibly eradicate, but I do believe that it is the minority and that we are neglecting the majority.

Chairman Wyden. So, you do not think there is a significant problem with respect to misleading or deceptive advertising? It is just a few cases?

Dr. Caleel. No; I believe that it does exist, but I believe that the percentages are that the majority of physicians are ethical physicians.

Chairman Wyden. Do you think a person doing cosmetic surgery should be required to have insurance?

Dr. Caleel. I personally believe that a physician would be ill-advised not to have malpractice insurance.

Chairman Wyden. Does your association recommend to its members that they have insurance? Is it the formal position of the association that its members have insurance?

Dr. Caleel. As an educational organization, the academy does not take the position to recommend the individual's personal practice.

Chairman Wyden. So, the organization has no position on the insurance issue, then?

Dr. Caleel. No.

Chairman Wyden. Doctor, do you believe that with the technological advances that have been made in surgical procedures over the last 30 years, that a person who has a medical degree and a State license should be allowed to simply declare that they are a specific type of surgeon?

Dr. Caleel. I do not believe that an individual with a medical license can declare themselves in any specialty area.

Chairman Wyden. That is what goes on, though, is it not? We have heard widespread testimony that someone with a medical degree and a State license can claim to be a surgeon with a particular specialty. That can take place, can it not?

Dr. Caleel. Yes; it can.

Dr. Chrisman. Can I make a comment, sir?

Chairman Wyden. If I could just finish with Dr. Caleel and then it would be good.

So, you said that it does take place. Do you think that that is right, given the technological advances in the last 30 years?

Dr. Caleel. No.

Chairman Wyden. Dr. Chrisman, did you want to add anything to that?

Dr. Chrisman. You said you had heard a number of claims that there are doctors all around from all sorts of specialties who jump into—I think you are referring to cosmetic surgery—I think you will find that those claims have been made by only one specialty and that they have no proof to document that. There is a very, very limited number of what you might call fringe doctors who are in the field of cosmetic surgery as I have mentioned earlier. There are just too many lawyers out there or doctors having some sense at all who would just go out and hang out a shingle about cosmetic surgery.

Chairman **Wyden**. But it is factually correct that anyone with a State medical license and a medical degree can declare themselves to be a surgeon. Isn't that correct?

Dr. **Chrisman**. I think it is true to say that that is factually correct, but to claim that that is reality is not true.

Chairman **Wyden**. It is not going on?

Dr. **Chrisman**. I do not believe it is to any significant degree, no, sir.

Chairman **Wyden**. Our committee has read the Yellow Pages and, certainly, from the Yellow Pages, it indicates that it is going on.

Dr. **Chrisman**. If you can find me any internist, cardiologist, or even a handful of family practitioners who are doing this, I would be surprised.

Chairman **Wyden**. We would be happy to share with you our reading of the Yellow Pages.

Dr. Caleel, what do you see as your academy's major hurdles to becoming recognized in the medical profession to achieving the status that you wish for your association?

Dr. **Caleel**. I believe that the academy as an educational organization has achieved the recognition of accreditation for their continuing medical education certificates which is the stamp of approval of organized medicine. So, I believe that the academy has achieved that. However, our publication, the Journal of Cosmetic Surgery, has been blocked from being listed in the Indices Medicas by the statement that the field is adequately covered by the Plastic and Reconstructive Journal. However, there are a number of journals in the fields of all specialties and not restricted to one journal. We feel that this is a separate problem that appears to be intensified by outside influence.

Chairman **Wyden**. When did your academy, Doctor, officially apply for admission to the American Board of Medical Specialties?

Dr. **Caleel**. I will explain that in just a moment. That question I will defer to my colleagues since that is related to the Board of Cosmetic Surgery and not the academy.

Dr. **Newman**. I may add one thing, Mr. Chairman. I think there is an overall cloud at this meeting amongst all the participants, there is confusion between an educational organization like the American Academy of Cosmetic Surgery and the Certifying Board of the American Board of Cosmetic Surgery.

The parallel is the American Society of Plastic and Reconstructive Surgery which is the parallel to the American Academy of Cosmetic Surgery and the American Board of Plastic and Reconstruction Surgery is the parallel to the American Board of Cosmetic Surgery. So, unfortunately, in speaking to many of the media people, they are totally confused when they come up to me and say, "Dr. Newman, how come your academy certifies these individuals?" So, that is a falsity which we must correct.

Chairman **Wyden**. Let me ask a couple of more of you, Dr. Caleel and then we will move on. The subcommittee has heard a number of complaints from your members that they have not been able to obtain hospital privileges for performing many procedures that they routinely practice in their office. Why are your physicians being denied these privileges?

Dr. **Caleel**. In many circumstances, the reasons are discriminatory. We support, as I stated, the American Medical Association's stand that privileges should be granted on the basis of training and experience and not certification. However, in many circumstances, the granting of these privileges is greatly controlled by the plastic and reconstructive members of the surgical staff in a given hospital and, therefore, they refuse to give the privileges despite the documentation of training and experience.

There are many cases of grievance that have been brought forward in that light. We do not feel that an individual who cannot establish appropriate training and experience should be granted privileges, but we strongly feel that those who can should be granted privileges on an equal basis.

Dr. **Chrisman**. Could I make further comment, sir?

Chairman **Wyden**. Sure.

Dr. **Chrisman**. I can speak from very personal experience in this regard. I applied with great trepidation to my own hospital for privileges in liposuction surgery. I was one of the earlier people in this country to start to do liposuction surgery, one of the first two in my State. I had a great deal of experience at it. I was teaching it at national meetings. I had done pioneering work in liposuction surgery under local anesthesia. I had written articles about it. I had an impeccable medical record, no malpractice suits. I had privileges in other things. When I came to my hospital credentials committee and my other peers in so-called surgical specialties and applied for privileges in liposuction, despite all of my credentials, which were impeccable in training, in experience, I had done 50 cases with no complications before I even approached them, it was an absolute stone wall. It was everything that I could do, I mean to the point of practically needing psychiatric care, for 3 years and finally with threat of lawsuit, I finally got those privileges. There was a major effort by a plastic surgeon in my community to keep me from getting those privileges and he was dumfounded when he failed. There was also a major effort on the part of three plastic surgeons in my State to keep another one of my colleagues from getting hospital privileges in a like manner who was even more trained than me because he had had liposuction training in his residency by that time and had letters of recommendation, even from the plastic surgeon who had trained him and he was thwarted from those privileges and is still fighting it to this day. It is just an absolute falsehood to say that any good doctor can get hospital privileges in this country. I have heard it too many times from too many people all across this country and from my own experience in my own State and other colleagues in my own State, it is quite true to say that many very qualified doctors cannot get hospital privileges in cosmetic procedures, whereas the plastic surgeons get them without batting an eye.

The plastic surgeon that was against my liposuction priveleges testified, reluctantly, when the other members of the hospital committee asked him how he got privileges in liposuction, since he claimed he had liposuction privileges at five other hospitals. He finally reluctantly admitted that the first hospital had given them to him simply because he was a plastic surgeon and the other four gave him the privileges because the first hospital gave him the privileges. He had absolutely no peer review at all and he had a major number of complications in his first year of practice at liposuction.

Dr. NEWMAN. Mr. Chairman, may I have the privilege of making a comment here, talking about blockage of privileges. There is such a dichotomy here. With one hand the American Medical Association talks about continuing medical education and the importance that you need for continuing your practice in the hospital and so forth, and the hospital says, "Well, how many credits do you have CME so that you could have your privileges?"

It is really ironic to think that at the graduate hospital and we have, I think, one of the only major departments of cosmetic surgery and we have taught more doctors cosmetic surgery than any other hospital in the United States. Would you believe that through the University of Pennsylvania, which graduate hospital is an affiliate, that all these years—and I think my workshops and symposiums in world congress are premier presentations—that we have been unable to get CME credits for all those doctors who attend? Many of those doctors are plastic and reconstructive surgeons, general surgeons. We have never been able to get CME credits because they have blocked us with the AMA and with the State and local societies. When I contacted the State AMA and said, "Why are you allowing them to do that to us? Why can't we qualify?"

Their statement was, "We have no control. If they won't OK it through the university, there is nothing we can do."

So, what they do is through one hand they say that we do not want to get better; on the other hand, they stop us. This is one of the problems we live with from day to day is condemnation and at the same time blocking us from doing the things that are proper.

Chairman WYDEN. One last question for you, Dr. Caleel. Do you think that an insurance company should give a doctor with a general practice and a background in general practice, medical malpractice insurance for, say, performing breast surgery?

Dr. CALEEL. I believe that if he can document his training and his experience, then I believe he should be considered for coverage of that procedure.

Chairman WYDEN. But what if he cannot? What if he is just a general practice MD and would like to get medical malpractice insurance for performing breast surgery, do you think they should have it?

Dr. CALEEL. That is not a valid question. He could also ask for brain surgery malpractice.

Chairman WYDEN. But that is the question I asked.

Dr. CALEEL. I understand that, but the question I find unanswerable because unless a man has training and experience in an area, then he should not be allowed to do it.

Chairman WYDEN. At this point, the Congress has not heard abuse in the area of brain surgery. That may be brought to the subcommittee, but there is no evidence that it has been brought to it to date. Why do we not just finish with this question? Do you think that absent any specific expertise and training, a proven track record, that an insurance company should give medical malpractice insurance to an MD with a general practice for doing breast surgery?

Dr. **Caleel**. Not unless he proves he is qualified.

Chairman **Wyden**. Thank you.

Dr. Newman, let me move on to you. How many doctors are board certified by your board?

Dr. **Newman**. Two hundred and fifty.

Chairman **Wyden**. Of those board certified, how many were in effect grandfathered into the board?

Dr. **Newman**. I do not know the exact number, but with all new boards, it is the group that puts it together that gets grandfathered in. That is the same way the plastic surgeons did it, but I cannot give you the number. I was grandfathered.

Chairman **Wyden**. Could we hold the record open and perhaps you could furnish that to us?

Dr. **Newman**. Surely.

Chairman **Wyden**. Now, I have heard reports that there were three plastic surgeons who attempted to form a cosmetic surgery board. Is that the case? If so, what can you tell us about that particular instance?

Dr. **Newman**. What had happened is that these very well respected plastic and reconstruction surgeons decided that they were going to form a board of cosmetic surgery. They went and incorporated in the State of California. They got incorporation papers, and, immediately, they did an investigation and found out that we were not incorporated in the State of California. So, they said, "Ha, ha, this board never really was organized." Therefore, went to the district attorney's office in Los Angeles, stated that we were an illegal board and that we should desist from our activities.

Unfortunately, they did not do their homework too well, because we were not incorporated in the State of California, we were incorporated in another State. We were functioning, we had the boards and the District Attorney threw the suit out and told them that they must desist and give up their board of cosmetic surgery.

Chairman **Wyden**. Now, Dr. Newman, is it correct that many of your members have chosen not to carry any insurance?

Dr. **Newman**. Truthfully, I have never done an investigation on that fact. So, I do not know who does or who does not carry any insurance. That is really out of my prerogative. I do not think it is my job to see who does and who does not. That is their own personal decision.

Chairman **Wyden**. You have gone to considerable trouble and considerable difficulty in attesting to the professionalism of your members. Do you not consider having insurance an attribute for professionals in the field?

Dr. **Newman**. We would like everyone to have insurance. I think it is very important. But, Mr. Chairman, please understand this: I have received numerous, numerous letters from doctors who were turned down for insurance coverage because of blockage from the insurance carrier, because on many of those boards, and many times they would contact the plastic surgical groups and they would state that they should not give insurance to these doctors. It is a blanket rule: They come down and say, "We will not give you insurance."

Now, if a doctor cannot in any way get insurance, do you expect him to give up the practice of medicine or his specialty and lose his livelihood? He cannot.

So, what I am trying to say is we want doctors to have insurance because you must protect the public. For a doctor to go bare and if you happen to hurt a patient and he can go after you, that is an injustice. I agree, Mr. Chairman.

Chairman **Wyden**. We are going to get into the politics later, but to do that, we first have to get it on the record.

Dr. **Newman**. I agree.

Chairman **Wyden**. I understood from your answer that you do not know how many of your people lack insurance.

Dr. **Newman**. That is right, but we want people to have insurance. The public must be protected. If there is an incompetent doctor who has done negligence, the patient must be compensated. It is not fair to the public. If they go bare, we have to correct that. But there can be blockage of these doctors that get carried.

Chairman **Wyden**. I understand your question about motives. I also note that your last statement contradicts somewhat with Dr. Caleel, because you said that you want your people to have insurance and Dr. Caleel said that the group takes no position.

Dr. **Newman**. Let me say this. He represents the Academy of Cosmetic Surgery. I represent the American Board of Cosmetic Surgery. We are talking two different hats.

Dr. **Caleel**. I would like to clarify that point. We have no official statement regarding it. As responsible physicians, we feel all physicians should have malpractice. I interpreted your question to mean did we have a formal policy statement.

Chairman **Wyden**. Dr. Chrisman, do you have insurance?

Dr. **Chrisman**. No, sir. I would like to comment on that, too. I'm glad you brought that up. It is a very important and difficult issue because you have just heard several of my colleagues voice the majority opinion of physicians and I respect that opinion. I have very strong opinions of my own in that regard. It was an agonizing decision for me about 9 years ago when I really went into cosmetic surgery as to whether I would or would not carry malpractice insurance. I would be quick to add that several plastic surgeons in my community do not carry malpractice insurance. Also, I do not know how rare it is in other communities, but it is not too rare in my community and it is a personal choice: Most hospitals in this country have made it mandatory to have insurance if you practice within the hospital. That is to protect themselves, not to protect the patients, I might add. That makes it very difficult for many physicians not to have insurance no matter how strongly they may feel about that philosophical issue. The group that I was in, a self-protection, self-insurance group of physicians in Hawaii, which was a very large and prominent group, at one time, literally folded because the hospitals required many of them to have insurance no matter what their philosophic feelings were. Only a few of us, such as some cosmetic surgeons and a few other specialists are in such a position where they do not necessarily have to be in the hospital and, therefore, they do not necessarily have to play the Russian

Roulette game which is what the malpractice insurance system in this country at the present time.

Frankly, sir, I try very hard to practice very good medicine. I probably keep at least as good records as anyone in the State if not better. I try to practice above the standard of care for cosmetic surgery in my State. The greatest risk that I have of getting sued for malpractice is not doing something wrong, but in all honesty, and I carefully considered this when I made this insurance decision, my greatest risk is one of my patients going to one of the plastic surgeons in the community who are against competitors and being told that I am unqualified, that I should be sued—and this has happened to me and to other colleagues—and suits are either attempted or actually instigated, patients have literally been sent straight to lawyer's offices, have been told which lawyer to go see. I frankly feel, again, that my greatest risk of being sued is having a malpractice suit instigated by certain members of the competing specialty of plastic surgery and not from my own patients per se. I have never been sued, after thousands and thousands of surgeries in the number of years of doing cosmetic surgery.

Chairman **Wyden**. But you would agree, Dr. Chrisman, that even a good doctor can have a bad day and that is the rationale behind insurance, is it not?

Dr. **Chrisman**. That is quite true. Many of my colleagues are amazed and it took me, as I said, an agonizing amount of time to make this decision, because you stand to lose a great deal: your family, yourself. You stand to lose a great deal from everything if you are sued successfully and you really have to make a very important philosophical decision if you decide to go bare.

I want to stress very strongly to this committee and any media person who is here that it is not just bad doctors who do not carry insurance, there are plenty of other doctors who have made a philosophic decision not to carry insurance. I am perfectly capable of getting insurance. I have been offered insurance at reasonably good rates. But there are so many nuisance suits in this country that just devastate your life if you are a conscientious person and become personally and deeply involved in such matters, if you feel strongly about the philosophy of it, that it is—I hope you can understand—a very difficult philosophic issue.

Chairman **Wyden**. I am concerned about that last statement that you made. I heard Dr. Newman talking about blockages and political motives and the like which strikes me as one of the issues we would want to examine. But unless I have missed something, you just said that you could get pretty good insurance at reasonable rates, but for philosophical reasons, you just chose not to get it.

Dr. **Chrisman**. If you do not mind me adding a few more moments of comments here.

Chairman **Wyden**. Is that not what you said, though?

Dr. **Chrisman**. I can get insurance. Now, it would not be cheap, but it would not be $100,000. But it would be maybe $30,000.

Chairman **Wyden**. You said reasonable good rates. Those were your words.

Dr. **Chrisman**. That is using relative terms. Reasonably good, maybe $30,000. That is Hawaii as compared to other States. It will go up every year. Once you are in that game, it is going to go up every year and get worse and worse.

The problem, sir, is serious psychological studies have been done to the effect on a doctor's abilities, his entire practice if he is sued. It is such a devastating blow to someone who has done a serious effort to practice well and it goes on for about 3 years. It is an unending travail, a great deal of money spent, no matter how innocent you are, once that occurs. So, once that suit is filed, once a claim is made, you are in a 3-year travail which will grossly effect you and your family and all of your patients. Of course, one way to try to keep from getting sued—and statistics show that the large majority of cosmetic surgery lawsuits are smaller suits settled for less than $25,000 in the end after perhaps 3 years of hassling—the best way to keep from getting sued, at least in my situation, as a nonplastic and reconstructive surgeon with competitors out there trying to get me, is to not have insurance.

Chairman **Wyden**. I do not know. I find that——

Dr. **Chrisman**. I know you do not agree with me.

Chairman **Wyden**. I find that a distressing comment. What Dr. Newman said raised questions about blockages and questions of political turf. That is a very different matter.

Dr. **Newman**. Mr. Chairman——

Chairman **Wyden**. Let me just finish this.

Dr. **Newman**. Go ahead.

Chairman **Wyden**. But the question of a physician saying that insurance is available at a reasonable price and I am told it is comparative to a variety of other ones, and still not to take it for philosophical reasons does concern me. I want to be on the record as reflecting that concern.

Let me just ask a couple of additional questions of you, Dr. Newman. Then I want to recognize my friend from Missouri, and then we will have some additional questions from the Chair.

Does the Cosmetic Surgery Board, Dr. Newman, require a surgical residency before taking the board?

Dr. **Newman**. In order to take our board, you have to have completed a residency in any one of the major surgical specialists. That is true. You cannot take the boards if you are residency in internal medicine, psychiatry, neurosurgery, neurology. It has to be and we have it so listed and that is true.

Chairman **Wyden**. Dr. Newman, if you will explain how the patient will benefit from the changes, the new changes that are forthcoming in board-certification requirements.

Dr. **Newman**. Yes; I think what we are doing is a major breakthrough in protecting the consumer. I just want to make it clear that despite everything you hear, the leadership in both the academy and the board are dedicated to protecting the consumer. We realize there are problems in any new organization, but we are trying to constantly upgrade.

What we are doing is by subcertifying doctors in a particular area, for instance, Mr. Chairman, if you would come into my office or Dr. Jones' office and you wanted to have liposuction surgery of your abdomen, it is very easy for someone to say he is board certified in cosmetic surgery or board certified in plastic and reconstructive surgery. It may mean that he never did any liposuction of the abdomen.

What our board is going to do is that we are going to subcertify doctors in all the major areas. That means we will subcertify them in body and extremity liposuction surgery, facial liposuction surgery, and all the other areas. So that when they look at their certificate and they ask them questions, they will see that that doctor has passed an examination in abdominal or lower extremity liposuction surgery. If he does not have that on a certificate, you know he has not passed an exam on body liposuction surgery. Now, another example why it is very important to understand all the problems. For instance, if I may just regress a moment. The plastic and reconstructive surgeons made a very derogatory remark about our 2-day workshops. First of all, they are not 2-day, they are 2½-days. Second,——

Chairman **Wyden**. You have kept your sense of humor—always to be commended.

Dr. **Newman**. Thank you. Second, they made the statement that they soon go out and start doing the procedure right away. That is true. Some do that. But a lot of those doctors are plastic and reconstructive surgeons who never learned it in their residency and I have many of those doctors who never, never, never had any liposuction surgery training come to our workshops and go out and do liposuction the next day.

Now, it does not mean that the general plastic surgeon knows more about general surgery than a gynecologic surgeon who opens abdomens, than an orthopedic surgeon who opens knees, than a general plastic surgeon who opens abdomens—I mean a general surgeon.

So, one of the problems is that there are doctors from all groups who do the wrong things. What is our position? That is the point. What is our position in the American Society of Liposuction Surgery, and we think it is better than theirs. One, we allow all surgical specialists to come in and not GP's and not neurologists, and not family doctors. That is a falsity.

Two, when they take our program, we recommend before they can become a member of the Liposuction Society that they must either take our 4 1-week observational training program with pioneers, experienced surgeons around the country, where they stay with them. They come to me at the graduate hospital, they stay a week right at my side, they are in the operating room, they see the procedures. They come to my office; they see the pre-op, the post-op, the complications, how we handle everything. That is something invaluable. We have our directly around the operating room table.

So, what we are trying to say is that we, despite what they say, try to make sure that our doctors do the right thing. If they do the wrong thing, please, Mr. Chairman, it is not because we have failed; it is because they have failed.

Chairman **Wyden**. One last question for you, Dr. Newman. The assertion that you have made, and others in your organization have made, is essentially that your board is every bit as qualified and exclusive, if you will, and offers as much expertise to consumers, essentially, as any other. Why not then throw out the real challenge to the others and just say, "My board will require facilities to be certified or they cannot be board certified by you."

Dr. Newman. Mr. Chairman, I so stated that in order to take the examination for the boards and if you do all your work in an outpatient facility, we will examine you and you will not be able to take the boards in cosmetic surgery unless we are there with a team and to go over with a fine-tooth comb whether you fulfill the criteria of an accepted facility. Mr. Chairman, we are doing it.

Chairman Wyden. I think that is important. Could you furnish us some data on what you have found in these visits? How many you have certified and how many you have not certified?

Dr. Newman. Mr. Chairman, we are inaugurating that because we realize that that is a problem because recently and with your hearings that we understand that this is a problem. I may say one other thing that we take a lot of credit in our organization, both the academy and the board. We move fast. We saw a problem. We decided to correct it. I challenge the plastic and reconstructive surgeons to make such changes in their whole philosophy to protect the consumer and to do the things that we feel that this committee has recommended. We are proud of what we are trying to do.

Chairman Wyden. The gentleman from Missouri.

Mr. Hancock. Thank you very much, Mr. Chairman.

As you gentlemen are well aware, I was unable to be here through the majority of the hearing. There are a few questions, though, that I would like to ask. We will have time to review your testimony. Maybe it has already been answered, but I would like to ask them anyway.

Dr. Caleel, do you have any type of a peer review mechanism set up by the board or have you established it in order to provide a continuing protection for the consumer?

Dr. Caleel. The Board of Cosmetic Surgery is a separate entity, as I stated earlier. Dr. Newman is president of that. He has outlined and I believe it is in the testimony that we are initiating not only the peer review of outpatient surgical facilities, unless they have appropriate accreditation, we are also instituting a program where at 5-year intervals, we will review the operative experience and the activities of our certified board members, yes.

Mr. Hancock. Thank you, sir. Have you set up any way to check out the quality of the members or the type of equipment in the outpatient facilities that your members might have where they are performing outpatient treatment?

Dr. Caleel. That will be the purpose of the on-site visits to unaccredited facilities. The accredited facilities, that is very tightly controlled.

Mr. Hancock. Does the American Academy of Cosmetic Surgery have any type of ongoing educational functions other than these 2½-day seminars that you mentioned, other than that?

Dr. Caleel. Yes; we have World Congresses. We have organized educational meetings. We have observational fellowship programs which were alluded to where the physician spends time with an individual experienced surgeon. The board has instituted a residency program. We have several fellowships, 1-year fellowships in postgraduate education.

We do have workshops. We produce video tapes. We have a journal which we publish. All of these are geared toward the continuing medical educational experience of our membership. Since 1984, we have held approximately 60 of these educational programs throughout the United States.

Mr. **Hancock**. I have a couple of other questions, but in the interest of time, maybe we can get them answered pretty quickly. Just what factors should a consumer consider when they start choosing a cosmetic surgeon? How do they go about getting the information? Can they get this information?

Dr. **Webster**. One of the main things we think, sir, is that there should be provided an organized American medical system, a way for a consumer to call some peer reviewing or accrediting organization and find out at least one fundamental thing—there are more that we would like to be able to provide—but one fundamental is really needed. Has Dr. Jones, the doctor that I have selected to do my nose job or my hair transplant operation, has he had what his peers consider to be adequate training and education in that procedure and has he met some requirement as to having done some minimal number of those procedures? Now, that is basic. It is not available today. We hope that through our board within the next 3 to 5 years that a consumer will be able to call and find out at least for any of our board members, has Dr. Jones done enough rhinoplasties, et cetra, to be considered experienced in that operation?. There should be some number that will be established as to a minimal number without which he cannot even pass his board in rhinoplasty, he cannot pass that part of it without meeting that fundamental minimal number. That is minimum.

Now, beyond that, we think that they should be able to ask: What is his educational background? What has he written on this subject? Does he teach it? If he teaches that subject, chances are that his peers think that he knows enough about it to be able to provide them with something valuable about that subject.

So, there are a lot of mechanisms that the educated consumer can try, even today, but none of them, and I am talking about all of the boards in American medicine today, not one can tell a consumer: Yes; your doctor has met some requirement as to an agreed upon minimum number of operations and that he has had, in other words, appropriate experience for that particular operation, that you are asking about, Mrs. Jones.

Dr. **Caleel**. Sir, if I may expand on that for just a moment. I read you a quote: "In my particular training program, little or no aesthetic surgery was done especially by the residents. When a young plastic and reconstructive surgeon hangs a sign on his door that says, plastic surgeon, the public believes that individual is well trained especially in aesthetic surgery. But, alas, such is not the case. While it is important to be certified by the American Board of Plastic Surgery, it certainly does not guarantee the consumer competence in aesthetic surgery." That is a quote from a world famous plastic and reconstructive surgeon, author of several books in his presidential address to the American Society of Aesthetic Plastic Surgery in 1987.

Mr. **Hancock**. Thank you. Actually, I think, Dr. Webster, you answered another question. In other words, I understand that the

American Academy of Cosmetic Surgery are setting up minimum standards. Is that correct?

Dr. **Webster**. Yes, sir. The American Board of Cosmetic Surgery, yes.

Mr. **Hancock**. You know, there is one other question that I would like to ask, though. Dr. Chrisman, you know, I am a small businessman. I am not a doctor and I am not an attorney and I have only been in the U.S. Congress for about 90 days now, so, I guess you might say I am a Congressman.

Chairman **Wyden**. You are a veteran.

Mr. **Hancock**. One of the things that I wonder about, though, after I quit a major company, I started to work selling insurance. I have had a lot of people give me a lot of reasons why they did not buy it, but I never did have one tell me that philosophically they did not want to buy it. I am curious of your definition of your philosophy or philosophically. That is a new one on me.

Dr. **Chrisman**. Let me give you a brief example. There was a collections expert in Hawaii, a very learned man who had an office larger than probably any of us, who had made a great practice and a lot of money doing that in the community and, of course, was greatly at odds with the attorneys in the community who liked to do the same thing. For many years, he did not have insurance. I believe it was 17 years he did not have insurance. Finally, all the attorneys and the engineers, doctors, architects, and everybody were getting insurance. He finally decided he should do it. The next 3 years, he was sued 27 times. He said, "I do not know how the attorneys found out I had insurance." He said, "I got to where I would sit down and have a cup of coffee with the deputy every time he brought in a new subpoena and just say, 'What have you got for me today, Fred.' "

He said, "Finally, after 3 years, I thought, you know, for 17 years I never had any lawsuits and now I practice the same way, but I have had 27 lawsuits in the last 3 years." He dropped his insurance and he has never been sued since.

Mr. **Hancock**. I am assuming then that you feel that the fact it is known that you do not have insurance has reduced frivolous lawsuits——

Dr. **Chrisman**. The statistics in Hawaii that were compiled by this physician group that is, as I say, practically defunct now because of the hospital requirements for insurance, showed that the doctors who did not carry insurance were being sued vastly less than the doctors who did carry insurance. Now, either they were incredibly good doctors or an awful lot of other doctors were being sued maliciously and frivolously. Of course, as I say, each and every one of those suits is just a massive threat and destructive influence in your life and your ability to practice.

Dr. **Webster**. Sir, may I add to that? Mind you, I have always carried insurance and philosophically I want to be insured. However, there is no question that in the tort system in America today many attorneys, even though they say it is important that we have a contingency fee system so that the poor but aggrieved patient can get his case before the courts. The actual fact is that many attorneys will not take on the case, even on a contingency basis, unless there is insurance.

Now, the reason for that is—the reason they will take it on is if there is insurance, they know that the insurance company will settle for the value of the nuisance case. So, they will get at least $5,000 or $12,000 or some nuisance suit figure out of it. Therefore, you invite—there is no question that you do tend in certain jurisdictions in this country to invite suits of that nature. That is the reason behind all of this debate. I think we favor having insurance, that we ought to bring it out here.

Mr. **Hancock**. Thank you very much. I just wanted the answer to that just in case I might need it one of these days. You never know. Thank you very much.

Dr. **Caleel**. Congressman, may I correct a small error. The date of that address, that presidential address was 1982, for the record.

Chairman **Wyden**. I have a couple of other questions, Dr. Webster and Dr. Chrisman. I find very distressing these comments about insurance. What you are basically saying is that because there are some questionable lawyers, some who have not followed ethical procedures, that in effect one should not have to have insurance.

Dr. **Webster**. I did not say that.

Chairman **Wyden**. That is the effect.

Dr. **Webster**. I was explaining to Mr. Hancock——

Dr. **Chrisman**. I did not say that either.

Dr. **Webster**. I was explaining to Mr. Hancock the fact. But, if you listened carefully to what I said, Congressman Wyden, I said that philosophically I feel strongly that we should be insured. I feel that it is more responsible for me to protect my family and my estate by being insured because the suit may be a big one. Even a superb cosmetic surgeon—I may not be that, but I was pretty good—is going to get sued sooner or later and he even may have a bad result. Those of us who have never had a bad result have probably never operated or were good liars.

Chairman **Wyden**. My friend from Missouri asked you about what educated consumers should ask about, Dr. Webster. Do you think it is important for an educated consumer to ask about the presence of insurance from a cosmetic surgeon?

Dr. **Webster**. I think it is a darned good idea, yes, sir.

Chairman **Wyden**. Dr. Chrisman, do you tell your patients on, say, the informed consent form that they sign, that you do not have insurance?

Dr. **Chrisman**. I was just about to add that, sir. I think that is important and my patients—I have an elaborate form which your staff has which talks about the surgery and also what the patient's responsibilities are in order to get a good result. The patient is asked to initial each and every paragraph of that significant amount of material. The last thing, right before they sign, is a statement that: I am hereby aware that Dr. Chrisman does not carry professional liability insurance. They must initial that, too. I must say I have only had one patient ever who objected and said, "Well, then I do not want to have surgery." I have had several attorneys and their wives smile knowingly as they signed it.

Dr. **Webster**. Congressman Wyden, may I add one——

Chairman **Wyden**. Let me just finish with Dr. Chrisman and then we will come back to you.

Dr. WEBSTER. I am sorry. Certainly.

Chairman WYDEN. What exactly does it say with respect to insurance, Dr. Chrisman? Does it say you do not carry insurance so you can pass the savings on to the patients or something along those lines?

Dr. CHRISMAN. It says something to the effect and I am paraphrasing a bit: In order to provide a wider range of procedures and at a lesser cost, Dr. Chrisman chooses not to carry—and it says "chooses not to carry"—professional liability insurance.

Chairman WYDEN. Dr. Webster?

Dr. WEBSTER. Congressman Wyden, I want to make sure that there is a basic understanding here. The fact that a doctor does or does not have insurance in no way excuses him from the responsibility either through his insurance or through his own funds for paying for some misdeed or for some malpractice act that he performs. I hope you understand that.

In other words, the doctor who has a bad result and is sued and is found guilty or a judgment is made against him, either his insurance pays or he pays.

Chairman WYDEN. Doctor, we are very much aware that that does not excuse misconduct, but it does provide the funds by which an individual can recover. We know that there are no funds, for example, if the person does not have insurance. We heard from our witnesses early this morning that there was great difficulty in getting attorneys to take the case.

Now, Dr. Webster, you were critical of the FTC's lengthy and expensive investigation of the Plastic Surgery Society. What was your assessment of the staff work that was done on that investigation and why were you so displeased with the FTC's investigation?

Dr. WEBSTER. I was not displeased. I felt that the Federal Trade Commission did an extraordinarily important and valuable thing for the American public by carrying out its investigation. I do not know where you got that impression, sir.

Chairman WYDEN. You were not displeased with the work that the FTC did on investigating the Plastic Surgery Society?

Dr. WEBSTER. No; I felt that it was very important that they did do that work and my personal feeling is that there have been so many abuses since that time my hope is that ultimately they will come back in and do some more because the deprivation or the restrictions put on good competition, healthy competition today that you are hearing about—lack of ability to get hospital privileges, lack of ability to buy insurance, lack of ability to put our ads of educational events into their journals—they are getting tax benefits right now on their journals and their educational activities. They are closing off a certain number of their meetings to their competitors so that we cannot go if we wanted to go and be educated in one of their meetings. Certain numbers of our people cannot go. There are many anticompetitive things that we think the Federal Trade Commission should activate again in lots of respects. I think you will hear more about that later.

Chairman WYDEN. What do you think of the job the FTC is doing in policing some misleading and deceptive advertisements?

Dr. WEBSTER. I think it is very inadequate at the moment. I think that while we are on that subject, sir, I think that any time an ad is put in that in one way or another implies superiority because a person has his boards in plastic surgery can at least to a certain extent be misleading or deceptive. May I go a little further with this?

Chairman **Wyden**. Sure.

Dr. **Webster**. All right. We just recently had in March 1989, we just recently had an investigator look at the jungle in Los Angeles and that area in cosmetic surgery. So, we had them look to just see what suits had been filed in the Superior Civil Court cases from 1979 through March 20, 1989. Now, I am going to take out of these figures some retired plastic surgeons and some people who would be called candidate members. The candidate members for the American Society of Plastic and Reconstructive Surgery are those who do not have their boards yet, or have not been out in practice long enough to become full members. So, we eliminated from that total study the candidate members, although I might add that 13 of the candidate members had suits filed against them in the short period of time that they had been in practice and 1 of those had 6 suits filed against him.

Now, of the 138 active members, they had 436 suits or over 3 each. One had 23 suits, another plastic surgeon had 27 listed, 5 had 10 or more, 33 had 5 or more suits. Two criticizing nonplastic surgeons on the TV tape had 5 and 11. There were at least 3 suits for wrongful deaths. Almost all of these 138 were board certified in plastic surgery.

Now, you should know that the American Society of Plastic and Reconstructive Surgery is the plastic surgeons' big society. In the smaller society that might be considered more concentrated in aesthetic work, of these 138 that we are talking about here, 47 were also members of that super society, their imitation of our cosmetic society. They had 150 suits or 3.2 suits each.

Now, just one last little statistic that might catch your fancy. Only 7 of the 47 who were members of American Society of Aesthetic Plastic Surgery, the American Society of Plastic and Reconstructive Surgery and had their boards in plastic surgery had no suits. One of these was also a president of—I will wait until you are all set.

Chairman **Wyden**. Please proceed.

Dr. **Webster**. One of these was a president of one of our organizations that formed the American Academy of Cosmetic Surgery. So, we just thought those statistics might be of some interest to you. We have them for other parts of the country, too. I think that you would find that having your boards in plastic surgery or being a member of ASPRS is no guarantee to the public that the people are not going to have problems with their cosmetic surgery. Thank you, sir.

Chairman **Wyden**. Thank you. Dr. Mangubat, let me ask a couple of questions of you. During the staff's visit to your office last month, you told the staff that you had learned to perform cosmetic surgery at the hands of Dr. Webster in Boston. In response to the question: How many hours do you believe you performed with Dr. Webster in terms of the overall number? You said after reflecting on it for a few moments, and I quote: "I'd say thousands of hours." Is that a correct statement, Dr. Mangubat?

Dr. **Mangubat**. That was a very off-the-cuff statement. At this time, in my testimony, I have stated, after talking to Dr. Webster, looking over my particular schedule that it is not thousands of hours. I have estimated 300 hours in concentrated sessions. In addition to that, I made several trips to Boston spending 1 to 3 days with him at a time.

Chairman **Wyden**. OK. The staff also made some effort to follow up at your office to determine some of the information that was disseminated and what the subcommittee was told on each occasion that they called was that you were board certified by the American Academy of Cosmetic Surgery. Are you board certified by the American Board of Cosmetic Surgery?

Dr. **Mangubat**. No, sir, I am not.

Chairman **Wyden**. Is that what was told our committee staff, because they made a number of calls and that is what they were told.

Dr. **Mangubat**. Not to my knowledge. We are in the process now of training new people. I have a list of my credentials and my training in front of the phone. At this point in time, because of the disorder created in my office during the preparation of my testimony over the past month, I have not been able to spend as much time with my new staff answering the phones. Obviously, I cannot personally answer the phone every time. However, it is clearly stated to my staff that I have not yet completed the board certification process. I am a fellow of the American Academy of Cosmetic Surgery.

Chairman **Wyden**. You might want to follow that up with your staff because that was something the committee staff found on a number of occasions.

Now, Doctor, in your testimony today, you said since opening your practice in April 1987, you operated on 246 patients performing 767 total procedures. You also referred to one of your patients who testified before the subcommittee earlier, Ms. Angela Brown. I just wanted to ask a couple of questions with respect to Ms. Brown's testimony.

Ms. Brown said, I quote: "He told me he had performed over 1,200 lipo-surgeries even though he was not board certified and I trusted his record."

Now, you testified under oath today that you performed a total of 767 cosmetic procedures in your life and that is all your liposurgeries, nose jobs, breast enlargements, and whatever else. How come Ms. Brown was told that you had done 1,200 liposurgeries?

Dr. **Mangubat**. Actually, if you recall her verbal testimony, when she tried to call me and verify those numbers, she said hundreds. I would ask that the committee look into the verbal testimony, after that correction on her part.

Chairman **Wyden**. So, you are saying that her verbal testimony was correct and her written testimony was not?

Dr. **Mangubat**. That is correct. That is the clarification.

Chairman **Wyden**. So, you feel that you did not lead her to believe that you were an expert at a procedure for which you had no formal training?

Dr. **Mangubat**. I would not exactly phrase it as not having formal training in this procedure. My formal training in this procedure was somewhat unusual in that I had first attended two seminars. Then a graduate of Dr. Newman's training program in cosmetic surgery happened to have set up practice in the Washington, DC area. His name is Dr. Roger Anderson. He began practice in our area in August 1986. I began assisting him in a full range of cosmetic procedures that he was doing in August 1986. When I opened my facility, Dr. Anderson operated in my facility and virtually every case that he performed in my facility, I scrubbed with him.

Chairman WYDEN. Do you believe that now looking back, that you could have more accurately characterized your experience level at doing that particular procedure with Ms. Brown?

Dr. MANGUBAT. I do not believe that I mischaracterized it with her. I think that maybe in her zeal to boost my character that maybe she picked a much larger number. Because, again, she called my office asking me how many procedures I did.

Chairman WYDEN. Why would she want to boost your character? She just wants to get a good operation done?

Dr. MANGUBAT. Because I corrected the surgical defects left by her first surgeon. The testimony that she submitted to this committee describes the problems she suffered at the hands of another surgeon that eventually brought her to me for repair.

Chairman WYDEN. So, you do not feel that you in any way had mischaracterized your formal training in this area, but that in her zeal to boost your ego, she inflated the numbers?

Dr. MANGUBAT. Absolutely not. I did not and have not mischaracterized it to her or anybody else.

Chairman WYDEN. How many times in your 2-year experience have you now performed the procedure you recommend for Angela Brown?

Dr. MANGUBAT. Three hundred and twenty-nine.

Chairman WYDEN. Gentlemen——

Dr. CALEEL. Mr. Chairman, may I make a comment, please?

Chairman WYDEN. Sure.

Dr. CALEEL. I would like just to state for the record that the procedure of liposuction was introduced into the United States in 1982. Without question, the majority of surgeons, be they cosmetic surgeons, plastic and reconstructive surgeons or whichever group they belong to, the majority of them learned this after their formal training program. So that this type of training is what has been obtained by the vast majority of surgeons performing liposuction in the United States today.

Chairman WYDEN. Does our recorder need a break there? All right.

Doctor, anything else that you would like to add? Dr. Caleel, I think we stopped because we thought our recorder needed a break. Did you want to add anything further?

Dr. NEWMAN. I think we all would like to thank this committee for coming down here to Washington.

Dr. CALEEL. But other than thanking the committee for the opportunity to participate and to present our status and position, we have nothing else to add. Thank you.

Chairman WYDEN. Very good. We will work with you in the days ahead and we thank you for your patience.

Dr. WEBSTER. Thank you, sir.

Dr. **Caleel.** Thank you.

Chairman **Wyden.** Our next panel, The American Academy of Facial Plastic and Reconstructive Surgery, Dr. Frank Kamer, president, Beverly Hills, CA; Dr. Ted Cook, president-elect, Portland, OR; Dr. Gaylon McCollough, Birmingham, AL; Dr. Robert L. Simons, North Miami Beach, FL; Dr. J. Regan Thomas, St. Louis, MO.

Let's have our seats and proceed here and try to move this along as fast as we possibly can. Are all our witnesses there at the table? We will swear all the witnesses. Do any of you have any objection to being sworn? Any objections?

[A chorus of nays.]

[Whereupon, the witnesses were sworn en banc.]

Chairman **Wyden.** Gentlemen, we welcome you. I know my friend from Missouri is short of time and I want to recognize him for any comments that he would like to direct to the panel before he may have to leave.

Mr. **Hancock.** Thank you very much, Mr. Chairman. I would like to just welcome Dr. Thomas to Washington, DC. I wish I could stay to hear the entire testimony, but due to the fact that the airplanes did not fly yesterday, I lost a day. At least they did not fly out of Southwest Missouri. But anyway, welcome. I am sure that the hearing will be conducted in a proper manner and you will be able to give full testimony. Thank you very much, Mr. Chairman.

Chairman **Wyden.** The Chair thanks my colleague and appreciates his participation. This certainly will be pursued on a bipartizan basis in the days ahead and we thank the gentleman.

I also want to welcome Dr. Cook from the greatest city on earth, Portland, OR. Thank you for your patience. We have to fly a little bit further than the Missourian, so, I know what that is about. We thank you and we welcome you.

Gentlemen, at this point, the 5-minute rule is going to have to be adhered to rigorously. It will be. We will begin with Dr. Kamer at this point. We will make your prepared remarks a part of the record in their entirety and no one will be severely penalized should they wish to go less than 5 minutes at this point, either.

Doctor, welcome and we look forward to your testimony.

TESTIMONY OF DR. FRANK KAMER, PRESIDENT, AMERICAN ACADEMY OF FACIAL PLASTIC AND RECONSTRUCTIVE SURGERY, BEVERLY HILLS, CA

Dr. **Kamer.** Chairman Wyden, thank you for letting us testify before your committee today. I am Dr. Frank Kamer. I live and work in Los Angeles. I am president of the American Academy of Facial Plastic and Reconstructive Surgery, the largest society of specialized plastic surgeons in the world. I am also a clinical professor of head and neck surgery at UCLA. I have maintained a private practice limited to facial plastic and reconstructive surgery in Beverly Hills, CA, for almost 20 years.

Let me begin by saying that my colleagues and I are shocked and appalled by the stories related by the patients who spoke this morning. This is not the practice of medicine as we know it to be. Our academy strongly supports the rights of Americans to principled and effective health care. Patients deserve high quality care. The best care comes from specialists. We feel that specialists in facial plastic surgery provide the best facial plastic surgery.

Insuring that the best care is provided in the specialty of facial plastic surgery is the reason why this academy began almost 25 years ago. On behalf of the American Academy of Facial Plastic and Reconstructive Surgery, let me say how much we appreciate the subcommittee's interest in the challenges facing consumers in their efforts to obtain the best facial plastic surgery.

Our academy is an interdisciplinary society attempting to further the education of those surgeons from various specialties who perform facial plastic surgery.

At the outset, it is important to understand that a number of surgical specialties overlap in performing facial plastic surgery. Overlaps are very common in many areas of medicine. As president of the American Academy of Facial Plastic and Reconstructive Surgery, I speak on behalf of more than 3,100 surgeons from all over the world who make up our academy.

The academy's by-laws require, and you can look at the chart, that fellows of the academy must have achieved board certification in one of the several disciplines addressing facial plastic surgery and that these certifications are recognized by the American Board of Medical Specialists. All of our fellows, in addition, must be fellows of the American College of Surgeons. Fellows of our academy must have demonstrated competence in facial plastic surgery. Also, our academy is a constituent specialty society of the American Medical Association and the American College of Surgeons. We celebrate our 25th anniversary this year. We only address surgery of the face, head, and neck. Our members have in common a special interest in surgery of that bodily region.

The academy believes patients in facial plastic surgery should come first. Physicians' economic needs and desires should take a subordinate role to the needs of patients. The academy's experience reveals that patients need two things for a high quality of facial plastic surgery. First, highly trained specialty surgeons focusing on facial plastic surgery. Second, a range of choices.

The first requirement is important. Patients needing facial plastic surgery should receive the highest quality of care from their surgeons. As I have indicated in these remarks, the academy seeks to assist in developing highly trained facial plastic surgeons. By emphasizing and encouraging advanced training, the academy attempts to train specialty surgeons focusing on the face, head, and neck.

The academy believes the best training in facial plastic surgery is the most specialized training. Training focusing on the head and neck provides the most highly specialized training currently available.

The second requirement for high quality patient care is equally important. The patient deserves choices in the marketplace. Without choices, the patient lacks consumer power. Our system of health care gives the consumer power when he has choices in the face of exorbitant fees or poor service. Without choices, the consumer is powerless.

The next several speakers from our academy will address these two requirements. That is: high quality facial plastic surgery oriented to the consumer's interest, high quality of training and the presence of choices in the marketplace.

Dr. Ted Cook, our next witness, is secretary and president elect of the academy. Dr. Cook is on the faculty of the Oregon Health Sciences University in Portland, OR, where he focuses on the teaching of facial plastic and reconstructive surgery.

After Dr. Cook, the subcommittee will hear from Dr. Simons, a former president of this academy who is in private practice in Miami. Dr. Simons will address the issues of directory listing and advertising.

After Dr. Simons, we understand you wish to hear from Dr. McCollough, another former president of our academy. He will address the problems created for the consumer by anticompetitive conduct that has the effect of limiting the consumer's choices in the marketplace.

Dr. J. Regan Thomas heads the Division of Facial Plastic and Reconstructive Surgery at Washington University in St. Louis. He will address the need for specialization in facial plastic surgery.

[Dr. Kamer's statement may be found in the appendix.]

Chairman WYDEN. Doctor, I thank you. But before we move on, I want to just say I am a little bit puzzled because I heard you during the first part of your statement commend the committee for its fine work in bringing these issues to light and concern for the patients and I just picked up a press release talking about the sensationalism and the lack of substance at the hearing. Which reflects your views? What you said in your testimony seems to certainly contradict the press release handed out today. I would be interested for the record which does reflect your views and if you are concerned about sensationalism, perhaps you could point to something about today's hearing that you thought was sensationalistic.

Dr. KAMER. We are all concerned about quality patient care and I think that is why we are here and that is why we appreciate you bringing us here, Chairman Wyden.

Chairman WYDEN. So, this press release really does not reflect your views? The press release talks about too much sensationalism and not enough substance at our hearing today held in this room from 10 a.m. to 4 p.m.

Dr. KAMER. The hearing is not complete, yet, so, I do not know how I can comment on what the contents of this hearing——

Chairman WYDEN. But you have not seen any sensationalism or lack of substance thus far?

Dr. KAMER. No.

Chairman WYDEN. OK. We appreciate having that for the record and thank you.

Dr. Cook, we welcome you and your prepared remarks will be part of the record in their entirety.

TESTIMONY OF DR. TED COOK, PRESIDENT-ELECT, THE AMERICAN ACADEMY OF FACIAL PLASTIC AND RECONSTRUCTIVE SURGERY, PORTLAND, OR

Dr. Cook. Chairman Wyden, I am Dr. Ted Cook. Thank you for inviting me to testify here before your subcommittee on the subject of patient protection. I am indeed a citizen of the city of Roses, Portland, OR, and a full-time surgeon and faculty member at the University of Oregon Medical School in Portland. My full statement is indeed a matter of record and I would like to present to you a summary of that statement.

Let me define for you what board certification is since it has been bounced around in this room a lot today. My board certification is in otolaryngology. The American Board of Otolaryngology examines and certifies physicians for competence in the various aspects of head and neck surgery, including facial plastic surgery.

Before sitting for the examination in otolaryngology-head and neck surgery, the candidate must have completed an internship and a residency training program in that field. As a full-time faculty member in one university otolaryngology-head and neck surgery program, let me explain to you what that training is in our program.

First, medical school for 4 years, second—I am sorry. First, college, 3 and 4 years; second, medical school, 4 years. Next, 1 to 2 years of general surgery providing for training in surgical principles. Then 4 to 5 years of otolaryngology head and neck surgery. This may be followed by a year's fellowship in facial plastic surgery.

By contrast, the general plastic surgeon again has college, 4 years of medical school, 3 years of general surgery, rather than the 1 to 2, and then 2 years of general plastic surgery. It is this issue which we are talking about: this time period here in facial plastic surgery or plastic surgery and the time devoted to the specialty training in those fields.

Otolaryngology-head and neck surgery residency programs teach both the functional and the aesthetic aspects of facial plastic surgery. Those otolaryngology residents train intensively in such procedures. Although I am not aware of any scientific study of the procedures or numbers thereof taught in various residency training programs, the straw polls which I have seen have indicated that otolaryngology residents perform more facial plastic procedures in their residency training programs than do general plastic surgeons. This is particularly the case at our university in Portland where in 1988, 734 facial plastic and reconstructive surgery cases were done in the Department of Otolaryngology-Head and Neck Surgery. In contrast, only 98 such procedures were done in the General Plastic Surgery Division of the Department of General Surgery. This is not an indictment of general plastic surgeons who must necessarily spend a substantial part of their training on other parts of the body. A surgeon must become proficient in surgery of the foot, hand, abdomen, breast, buttocks, and thighs and cannot be expected to focus on just the face, head and neck. It is, however, an affirmation of the extent of training in facial plastic and reconstructive surgery provided to residents in otolaryngology head and neck surgery training programs throughout this country.

Following the completion of this residency training program in otolaryngology and sitting the exam by the American Board of Otolaryngology, the physician may elect to pursue a 1-year fellowship in a facial plastic and reconstructive surgery through the educational foundation of our academy. That year of fellowship requires research, intensive hands-on experience in full-time facial plastic surgery, constant exposure to all aspects of the care of the patient who has had facial plastic and reconstructive surgery and still another examination.

In summary, the person trained in otolaryngology head and neck surgery and certified by the American Board of Otolaryngology is well trained in facial plastic surgery. The matter of quality of that training in facial plastic surgery was gratefully acknowledged today by Dr. Jarrett also from our State. But there is a public relations and advertising campaign by the American Society of Plastic and Reconstructive Surgeons, which I feel is deceptive, which advertises that group as the only group board certified by an ABMS-recognized medical specialty board to practice plastic surgery.

The ABO, the American Board of Otolaryngology, examines and certifies in a facial plastic and reconstructive surgery and this fact is well known and well recognized by your excellent staff in their examinations over the past few months. I thank you again for the opportunity to appear before you, Congressman Wyden, and to be able to explain these parts of board certification to the committee. Thank you.

[Dr. Cook's statement may be found in the appendix.]

Chairman WYDEN. Doctor, thank you very much. It is good to have you here and we will have some questions in just a few moments.

Dr. McCollough.

TESTIMONY OF DR. ROBERT L. SIMONS, FORMER PRESIDENT, AMERICAN ACADEMY OF FACIAL PLASTIC AND RECONSTRUCTIVE SURGERY, NORTH MIAMI BEACH, FL

Dr. SIMONS. If you do not mind, Mr. Wyden, I would like to next——

Chairman WYDEN. Without any objection, so ordered.

Dr. SIMONS. I am Dr. Robert Simons, former president of the American Academy of Facial Plastic and Reconstructive Surgery who is now in practice in Miami Beach. I thank you for the invitation to appear before your subcommittee today.

I understand you want me to talk about advertising and listing in directories. As a facial plastic surgeon in private practice in Miami for more than 16 years, I have seen a number of disputes among physicians about listings in directories and an increasing amount of advertising.

The American Academy of Facial Plastic and Reconstructive Surgery neither encourages nor discourages advertising. The academy has a strong ethical policy against misleading advertising. It does note, however, that informative advertising and directory listings can provide helpful information that gives the consumer power in the marketplace.

Advertising and directory listings raise a serious issue. Consumer power in the marketplace. Let me begin by stating a basic truth. Consumers benefit from having choices among qualified surgeons.

Let us take the case of a patient. We will call her Mary Jones in a town in New York. Mary was in a car accident last year. The emergency room surgery unavoidably left scars on her face. She is looking for a facial plastic surgeon to make the scars less noticeable. She has to stay in her area because she has small children at home.

Mary goes to her directory and finds only one surgeon listed under plastic surgery. She goes to that surgeon. Let us call him Dr. X. She has to wait almost an hour to see him and Dr. X turns out to be insensitive and his staff rude. Dr. X quotes her a price that she considers too high. She does not feel comfortable with him. When she mentions another surgeon that she has heard of, Dr. X tells her that the other surgeon is not qualified. Dr. X tells her that the other surgeon was trained in his garage and has not received staff privileges for facial plastic surgery at the most prestigious hospital in the area. He pulls out an article in the local Sunday news magazine that quotes Dr. X as saying that the other surgeon is incompetent.

Mary still does not feel comfortable with Dr. X. She still feels like his price is exorbitant. But he has naturally scared her about the other surgeon.

What are Mary's choices? Can she vote with her feet, the way she could if she did not like the service or the prices in a normal consumer transaction? No; as a practical matter, she is stuck with Dr. X. She has no consumer power. She must pay what he demands and endure whatever rude treatment he chooses to provide.

Mary, like other consumers, needs choices to have power in the marketplace.

Dr. X can obtain power over consumers like Mary, if he is able to keep other qualified surgeons from being listed in the directory, and if he prevents other qualified surgeons from providing useful information in advertisements. Recent efforts to limit advertising have focused on requiring only the official name of the examining board to be used in advertising of directory listings.

By sticking the otolaryngologist-head and neck surgeon with a Greek name, incomprehensible to most prospective patients, the general plastic surgeon obtains a strong marketing advantage.

We have enlarged, for the committee's examination, some advertisements by general plastic surgeons, showing the use they attempt to make of their English name.

The first advertisement includes the name of one of the general plastic surgeons who testified this morning. His advertisement implies, incorrectly, that his certifying board is the only recognized board addressing plastic surgery.

The second advertisement bears the logo the General Plastic Surgeons National Society, the ASPRS. The ad urges consumers to avoid unqualified plastic surgeons and go only to general plastic surgeons.

By implication the ad states that competing specialties are potato-heads who do not provide training in facial plastic surgery, which is not true.

The third example is a cartoon appended to an article by a general plastic surgeon in Arizona, who is arguing that only general plastic surgeons should be allowed to perform plastic surgery.

Such misleading advertising carries the potential to deceive the consumer into believing that only general plastic surgeons are trained or competent to perform facial plastic surgery.

The consumer deserves the opportunity to make informed choices. Attempts to limit these choices by limiting directory listings and advertising work against the consumer and should be rejected.

I thank the committee for their attention.

[Dr. Simon's statement may be found in the appendix.]

Chairman WYDEN. Doctor, thank you. Dr. McCollough, would you like to proceed next?

TESTIMONY OF E. GAYLON McCOLLOUGH, M.D., PAST PRESIDENT, AMERICAN ACADEMY OF FACIAL PLASTIC AND RECONSTRUCTIVE SURGERY, BIRMINGHAM, AL

Dr. MCCOLLOUGH. Thank you, Congressman Wyden and distinguished members of this committee. I am Dr. Gaylon McCollough.

I am board certified in otolaryngology. But since the day I completed my training in 1975, my practice has been confined strictly to facial plastic surgery in Birmingham, AL.

As a matter of fact, I chose otolaryngology because after reviewing all of my options, I became convinced that it provided me with the most comprehensive training in the head and neck region.

I appear before you today as a past president of the American Academy of Facial Plastic and Reconstructive Surgery, and as a physician concerned about unfair trade practices.

On the exhibits before you are excerpts from a plan that appears to have been designed to create a medical monopoly. After an exhaustive investigation, the staff of the Federal Trade Commission concluded that general plastic surgeons are involved in a conspiracy to block other specialists from performing plastic surgery and that the conspiracy deceives consumers.

The fact that one group of specialists would even consider a campaign to "stall, frustrate, deceive, suppress or resort to guerilla warfare tactics" against other specialists they identified as competitors, has given the medical profession a black eye.

General plastic surgeons, even after being sworn in this morning, have been misinforming you, Congressman Wyden, and the other members of this committee. I refer to a sworn deposition of Dallas Whaley, the ASPRS former executive director in the Supreme Court of Fulton County, State of Georgia, Civil Action File Number C–93931.

Mr. Whaley testified that the document was distributed to the ASPRS leadership. The record suggests that for over 25 years, an entrenched group of general plastic surgeons has conducted what the leadership labeled as a cold war.

In this document, the strategists explained how tactics similar to those used in Vietnam could be used by guerilla warfare teams when other specialists were making inroads and the general plastic surgeons felt their cause was being lost.

Soon after the cold war plan was written, guerilla teams were dispatched in Louisiana and in Arizona. Later, similar attacks appeared in Georgia, Maryland, Texas, and in many other States.

In Louisiana, a former patient of a nationally prominent facial plastic surgeon has testified that he was persuaded by general plastic surgeons to file a patently groundless malpractice suit against one of this academy's most outstanding leaders.

The jury saw through the charade and justifiably vindicated the doctor.

In Arizona, an article was published by a general plastic surgeon attacking other specialists performing plastic surgery as unqualified pretenders.

More recently, the same surgeon's efforts led to the degrading chain saw cartoon shown to you a moment ago by Dr. Simons.

A guerilla team in Georgia republished the Arizona article, which, among other things, claimed that general plastic surgeons are cream and that other named specialists were skim milk masquerading as cream.

The Georgia courts recognized the wrongdoing. A jury returned a $1.5 million judgment against that guerilla team.

As a physician concerned about these black marks against the medical profession, I urge all parties who are in a position to do so to take appropriate measures to see that anyone perpetrating unfair trade practices cease and desist or suffer the consequences.

In conclusion, the bad results projected by Dr. Gorney this morning are indeed unfortunate. However, they represent an extremely small percentage of the 2 million patients who undergo cosmetic plastic surgery each year.

Facial plastic surgeons agree that plastic surgery is best performed by trained specialists.

However, we strongly disagree that any single specialty ought to seek or be granted exclusive privileges.

Let me close with a warning issued by a former President of the United States. President Andrew Jackson said every monopoly and all exclusive privileges are granted at the expense of the public.

I thank you for giving me the opportunity to address you.

[Dr. McCollough's statement may be found in the appendix.]

Chairman Wyden. We are happy to have you with us, and we will have some questions in just a moment.

Dr. Thomas, I think we may have missed you.

TESTIMONY OF J. REGAN THOMAS, M.D., DIRECTOR, DIVISION OF FACIAL PLASTIC AND RECONSTRUCTIVE SURGERY, DEPARTMENT OF OTOLARYGOLOGY, WASHINGTON UNIVERSITY SCHOOL OF MEDICINE, ST. LOUIS, MO

Dr. Thomas. Everyone all day today has thanked you for letting them be here. But at the risk of sounding like a constituent tourist from back home, I genuinely am enjoying not only seeing the process, but now being able to participate. So thank you for letting me be here to represent these issues in my position as a medical educator, where I am the director of the Division of Facial Plastic and Reconstructive Surgery in the Department of Otolaryngology at Washington University School of Medicine in St. Louis, MO.

In addition to that full-time academic position, I am also the vice president for Education in the American Academy of Facial Plastic and Reconstructive Surgery.

My various positions in medical education have allowed me to develop some familiarity with the educational programs in general plastic surgery and in facial plastic surgery.

Medical studies universally indicate that patients receive better care from the specialist. The history of medical specialization has been a progression from the old-time country doctor who tried to treat everything to a modern regional specialist in particular areas of the body.

Today, for instance, there are specialists in hand surgery and ear surgery and brain surgery and eye surgery, and almost every part of the body. Most physicians agree that regional specialists who develop a special expertise in a single area of the body offer enhanced patient care.

The phenomenon of regional specialization also appears in plastic surgery. As you have heard, there are two basic specialties that overlap in their performance of facial plastic surgery—the specialty of general plastic surgery and the specialty of facial plastic surgery which is a subspecialty of otolaryngology-head and neck surgery.

General plastic surgery, as you now know, addresses the whole body. The general plastic surgeon receives training and operates on the entire body. He performs surgery on the hands, feet, buttocks, and breasts, as you have seen, and also sometimes on the head and neck.

The facial plastic surgeon focuses all of his or her entire training and career in the head and neck region.

Both the training of the general plastic surgeon and the training for the facial plastic surgeon requires at least 9-years of post-graduate training after the 4 years of medical school, as you have seen.

The super specialization in facial plastic surgery, however, is increasingly being recognized as the preferred course. A study in the General Plastic Surgeons Journal of November 1985, reported that approximately half of the graduating residents in general plastic surgery that year felt that their plastic surgery training was inadequate in duration given the need as they saw it for regional specialization.

The study concluded that the traditional 2-year residency program in general plastic surgery is inadequate for facial plastic surgery. A report in the Plastic Surgery News by the American Society of Plastic and Reconstructive Surgeons, this is the general plastic surgeons' official newspaper, just last month, reported an overwhelming majority of general plastic surgeons—it was 63 percent—felt that it was impractical to try to maintain a clinical practice in all the areas of general plastic surgery. At least 71 percent of the respondents said they regretted the narrowing of the scope of plastic surgery that now seemed to be a fact of life.

Super specialization in facial plastic surgery helps the patient. A patient who goes to a facial plastic surgeon for rhinoplasty, plastic surgery of the nose, for example, can be confident that that physician has seen almost every possible type of condition that can affect breathing as well as the appearance of the nose.

The occasional surgeon, and those are the words in the general plastic surgery article, performing that surgery, is not nearly as likely to have comparable experience in complications affecting breathing.

We were all saddened to see the former patients brought before the committee today. But you may be assured that I and the other facial plastic surgeons here have seen hundreds of unfortunate surgical results in surgery done by other physicians—some board certified in general plastic surgery. Many of those patients would have received better care had they gone to a facial plastic surgery specialist.

Specialization in facial plastic surgery, gentlemen, is of great benefit to the patient. I urge you in Congress and perhaps the regulatory agencies to foster and support that concept of specialization. Thank you.

[Dr. Thomas's statement may be found in the appendix.]

Chairman **Wyden**. Thank you very much, Dr. Thomas. Let me begin with you, Dr. Kamer. You are the president. Let us start with you.

I would like to start by asking you essentially the same questions that I have asked the heads of the other professional associations, at least initially, to try to get us out of this debate between one association or another.

Is it your view that overall, not in your particular discipline but overall, that the number of quacks and charlatans in the cosmetic surgery field is growing?

Dr. **Kamer**. I do not believe so. I think they are more obvious. Whether their numbers are growing I do not know.

They are making more noise. That is true. We are seeing a lot more in the newspaper and the media about them. That is true.

As far as absolute numbers, I cannot answer that question.

Chairman **Wyden**. Do you feel that there is a significant amount of misleading or deceptive advertising now in the cosmetic surgery field?

Dr. **Kamer**. There is certainly a lot of advertising now in the cosmetic surgical field. We in the American Academy of Facial Plastic and Reconstructive Surgery have definitive guidelines for false and deceptive advertising and that is a difficult parameter, as you well know.

Chairman **Wyden**. So you are not of the view that there is a significant advertising problem at this point?

Dr. **Kamer**. No.

Chairman **Wyden**. OK; Doctor, has any physician ever been removed from your society, removed by action of the various self-regulating procedures you have for incompetence to perform procedures?

Dr. **Kamer**. We have. Our credentialing system is the strictest and most stringent of all that you have heard today. So in order to become a full fellow of our academy, one must not only be board certified, showing a certain base proficiency in his or her specialty, but in addition, become a fellow and be a fellow of the American College of Surgeons.

We have not, to this date, had to expel anyone from our society.

Chairman **Wyden**. So no one has been expelled for incompetence, but it would be your view that you have set the threshold so high in your own terms, that that makes it less likely that an incompetent would slip in and that you would have to take the action?

Dr. **Kamer**. There is no threshold so high that an incompetent could not squeak through, in any field.

Chairman **Wyden**. How many complaints have been filed with your organization with respect to individual physicians?

Dr. **Kamer**. I do not know the answer to that question.

Chairman **Wyden**. Perhaps 10, 100, 1,000?

Dr. **Kamer**. I have no idea. But perhaps we could provide that information.

Chairman **Wyden**. We will hold the record open on that point, because that is something I would be very interested in knowing.

Now, is it correct that some physicians in your organization advertise themselves as being certified to do procedures that they are really not certified to do? In effect, some go beyond the question of facial plastic surgery, go beyond the face and the neck, to other bodily regions. Is that kind of work being done by some of your practitioners?

Dr. **Kamer**. We in the academy only address the face, head, and neck. The vast majority of our membership limit their practice to that area.

Chairman **Wyden**. What is done when one of your practitioners goes beyond? That is my question.

Dr. **Kamer**. We are not a credentialing body, Chairman Wyden.

Chairman **Wyden**. Do you know how many do go beyond that area that you have certified them to do?

Dr. **Kamer**. I do not know the exact number.

Chairman **Wyden**. But a ballpark?

Dr. **Kamer**. I would say 5 percent.

Chairman **Wyden**. Five percent. The only other question that I wanted to ask of you, Dr. Kamer, is to tell us a little bit about your standards for advertising within your organization. What are the general guidelines for what would be acceptable and what would not be acceptable?

Dr. **Kamer**. Our guidelines are quite stringent, and we will provide those to you in written form from our bylaws.

Chairman **Wyden**. Can you give us a little bit of information on what would be acceptable and what would not be acceptable?

Dr. **Kamer**. Providing promises that cannot be fulfilled. Certainly providing false images that cannot be fulfilled. There are many, many others, and you can peruse that at your leisure.

Chairman **Wyden**. Are you concerned—you have said that you do not think there are widespread advertising problems. I would note that that is essentially the only testimony we have heard today to that effect. Essentially all of the other groups regardless of their position in this debate, have essentially indicated that there were significant advertising problems.

Are you at all concerned that health care, cosmetic surgery specifically, is now in effect being marketed like razor blades or new cars?

Dr. **Kamer**. Yes.

Chairman **Wyden**. You are, but you do not feel it is widespread at this point?

Dr. **Kamer**. I think the numbers, the percentages of surgeons who are advertising is low.

Chairman **Wyden**. Overall?

Dr. **Kamer**. Overall.

Chairman **Wyden**. That is interesting, and a comment we have not heard. Have you all done an assessment of the number of cosmetic surgeons that are advertising?

Dr. **Kamer**. The number of facial plastic surgeons?

Chairman **Wyden**. Of facial plastic surgeons specifically or cosmetic surgeons generally.

Dr. **Kamer**. I cannot speak for cosmetic surgeons.

Chairman **Wyden**. With respect to your own organization, it is low?

Dr. **Kamer**. Yes.

Chairman **Wyden**. About 5 percent, 10 percent?

Dr. **Kamer**. I could provide a better figure for you. I do not have it offhand.

Chairman **Wyden**. OK. Let me just move on right down the line. Dr. Cook, as I say, we welcome you and I appreciate the comments you made with respect to consumers getting choices because that, of course, is a key aspect.

But we have heard considerable testimony today that it is very difficult for consumers to make good choices.

Again, virtually everyone who has come forward has said that it is very hard if not impossible to figure out who would be a bad surgeon as opposed to who would be a good surgeon.

What steps are being taken, and now you will ascend to the presidency I gather here shortly, what steps are being taken so that consumers can make reasonable choices when they have so much conflicting information coming at them?

Dr. **Cook**. It is our position in the American Academy of Facial Plastic and Reconstructive Surgery to provide the best quality level of training for all of those in otolaryngology residency training programs and in our fellowship program.

Furthermore, we provide to the public access to the list of those who are full fellows of the American Academy of Facial Plastic and Reconstructive Surgery. As Dr. Kamer told you, that means three steps for us: No. 1, board certification; No. 2, it is a bylaws requirement that our fellows, full fellows, be fellows of the American College of Surgeons; and No. 3, they must pass our credentialing process through the credentials committee, to become full fellows.

That last step is rather stringent and it does take some review after 2 years and following the American College of Surgeons certification.

So what we try to do is to provide the public with a list or with access to those who we feel are the best trained to do facial plastic and reconstructive surgery.

Chairman **Wyden**. Have you done any kind of survey of consumers to try to determine what they find workable and helpful?

I think these are very laudable efforts, as has been much of what we have talked about today. But I think consumers are absolutely baffled. I think they have nowhere to turn. I think they find it very difficult to distinguish between these various kinds of groups. I think that this is technical——

Dr. **Cook**. I share your concerns for that. I mean, even today, half an hour ago, I was defining what board certification is. I know that two of your staff members with whom I have spent a considerable amount of time talking about it spent 1½ months to 2 months, trying to sort it out and only about a week ago got their scrub suits to testify to it.

But it is a difficult situation. It is very difficult. Board certification, alone, I agree is not adequate, because we have heard that those board certified by all the different groups, there are still those who may not practice at the highest level.

The only thing that I an tell you is that board certification, reputation in your community with your medical community, I think is absolutely impossible to best as a reputation factor. That has been debated earlier today, but I take exception to that. I think a person's reputation in his community and board certification and patient reputation are the hallmarks for me, and not Yellow Pages advertisements, newspaper advertisements, or airline magazine advertisements.

Chairman **Wyden**. Doctor, do you think that the multiple board affiliations—there are some that your members are associated with and there are some that other surgeons are associated with—have these multiple board affiliations contributed to the confusion among consumers?

Dr. **Cook**. I think there are lots of choices to the consumer today. I am confused when I look at the advertisements for different computer companies and different computer products.

I do not mean to be facetious, because I think the choice and the reason that is burgeoning is a very similar thing. Medicine is becoming very super specialized and it is evolving to the need for more certification and more board certification, more specialties. I really believe that.

To say that the 23 boards recognized presently by the American Board of Medical Specialists is adequate is fallacious and misleading, I think today——

Chairman **Wyden**. I appreciate that. But my question is, the multiple board affiliations it seems to me is part of what causes the confusion among consumers.

Dr. **Cook**. I am sorry. I misunderstood you.

Chairman **Wyden**. Do you agree with that?

Dr. **Cook**. You mean affiliations with multiple boards?

Chairman **Wyden**. There you are. You are sitting there on Southeast Division, Portland, in the beautiful Third Congressional District.

Dr. **Cook**. You just moved me across the river, Congressman.

Chairman **Wyden**. Somebody sees all these memberships and all these affiliations.

Dr. **Cook**. Yes.

Chairman **Wyden**. Does that not contribute to some of the confusions?

Dr. **Cook**. Unfortunately I think that is a corollary of what we have been talking about, yes, sir.

Chairman **Wyden**. I am going to move on and thank you. Actually, just one other point.

I think you said, Dr. Cook, that out-of-hospital surgery offers the patient several distinct advantages, among them cost savings.

But it is a fact that there is also some down side as well, is it not, that outpatient facilities may not have life support systems?

Dr. **Cook**. Absolutely, and you are reading from my prepared statement, and there were two other points I made, and those, I think are the most important. The third one, I feel is the most important. That is that outpatient hospital surgery—and I believe that it must be certified; I believe very strongly in that. I do all my surgery as an outpatient and have done for 10 years. I believe in it very much, because it is less traumatic to the patient and it is safer for the patient, done in a good setting.

It requires less medication, less sedation, and the patients generally receive it much better.

So I believe it is safer, if it is done in a certified setting. Yes.

Chairman **Wyden**. Let me move on. Dr. Simons. You said, in your testimony, focusing on advertising, some of the advertisements might be a little aggressive, overly aggressive were the terms that you used, but they were not deceptive.

One of the things that has concerned me that we have not talked about today is basically all the advertisements that I seem to be running across, basically just focus on the up side. They talk about the positives—look good, its painless, be attractive and the like. But none of them seem to talk at all about the down side. Isn't that a little bit misleading, in and of itself, to not focus at all on the downside?

Dr. **Simons**. That may be the aggressive nature of advertising.

Chairman **Wyden**. Pardon me?

Dr. **Simons**. I say, the nature of the advertising industry may indeed be aggressive and a little deceptive in the way that you suggest.

Chairman **Wyden**. Should not medical advertising be a little bit different than advertising a computer or some other product?

In medical advertising, you have somebody incompetent and you may die. If you buy a bad computer, maybe you are going to be wiped out financially, but you are not going to die from it. It is a little bit different, is it not?

Dr. **Simons**. What is important, I think, in medical advertising is that it be truthful, that it be honest, and that it be clear to the consumer.

When we spoke in terms of, in the text, that there was not a special problem of deceptive advertising in facial plastic, I did not mean to infer that there was not a problem in the sense of the consumer at times being misled.

I think that the statements have been made here today by the general plastic surgeons and certainly there is much evidence that to find the appropriately trained physician to do the type of surgery you wish you must find one that is boarded in plastic surgery, that that is the only board recognized in today's world of medicine. That is not true. That does not provide an honest choice to the patient.

I think that the surgeon, when he is seen and consulted with, certainly must be honest with the patient in the pros and cons of the surgery that they are contemplating. Coming to that surgeon hopefully through honest information, meaning giving the certification that they have, providing them with the information of their expertise, will then further be added to in the consultation with that surgeon as to the up side as well as the down side of the surgery that they are contemplating.

Chairman WYDEN. But you would agree with my general statement that at this point basically with respect to cosmetic surgery advertising, the patients usually get the up side but not much in the way of the down side?

Dr. SIMONS. I would.

Chairman WYDEN. Given that, do your advertising guidelines, do they try to take steps to balance it out? I have not heard any mention of that. I asked Dr. Kamer for some comments about your own advertising guidelines. Do your advertising guidelines suggest that the down sides as well as the positives should be outlined?

Dr. SIMONS. I think when you talk in terms of guidelines and not misrepresenting facts, and not presenting unrealistic photos or diagrams, and not suggesting a quality of efficiency for the medical care that is unrealistic or not in the typical experience of surgeons, in claiming superior skills, but results, or even taking improper advantage of applying to patients' vanities, anxieties, or similar emotions, all of those things are covered in ways of trying to avoid bad advertising.

Chairman WYDEN. I think that is useful. But again it does not seem to me to be very specific. When you talk about the positives, it does seem to be very, very specific. You tell people how much fat they can lose. They are told how many inches will disappear from here and there. But when it comes to the negatives, when it comes to the down side, they seem to be very generic. I think this is one area that we are going to want to work on with you all and the Federal Trade Commission. Because I think that we need to have some strong ground rules in this area.

I do not think it is something probably that needs legislation. I think it is something the Federal Trade Commission can do with its existing authority.

Dr. SIMONS. Can I add, Congressman Wyden, that one of the most recent efforts of our academy was to present to the consumer and the public a free book which covered the pros as well as the cons of facial plastic surgery, to provide them a realistic understanding of what they might expect and what is unrealistic. So your concern is not one that is not our concern as well.

Chairman WYDEN. Dr. McCollough, let me just ask you a question through your reference to the FTC investigation with respect to restraint of trade.

You talk about an FTC report in which there was a conspiracy led by plastic surgeons that foreclosed consumers from freedom of choice among physicians. Could you elaborate a little bit on that?

Dr. **McCollough.** The body of that report I think is contained in my statements that you have in front of you. That information, quite frankly, was given to me by the academy's legal counsel.

Chairman **Wyden.** So you do not want to elaborate at this point?

Dr. **McCollough.** I do not know much more to elaborate about the report except that I have seen a copy of the consent agreement which was offered and I am familiar with many of the other documents which the FTC obtained from the records of the headquarters of the General Plastic Surgery Society, and it is really from those documents that my presentation was prepared.

Chairman **Wyden.** Dr. Thomas, one question for you. You and some of your colleagues noted that many of the procedures done by your colleagues are performed outside of the hospital—one, because it is less expensive and two, because members may not have privileges to perform the specific procedure.

Would you agree with the assertion that not all of these nonhospital operating rooms are really up to the standards we would like, with respect to equipment and trained personnel?

Dr. **Thomas.** Yes; I do not believe I said that, Congressman. But I would agree in general terms that certainly there are stipulations that I think for safety of patient care, that we should all require of outpatient facilities.

There are a variety of accrediting organizations now available to do just that as well as I have heard from different board and specialty groups, to help to maintain those standards as well.

Chairman **Wyden.** But even given those variety of accrediting organizations, there are a fair number of these outpatient facilities that are still falling between the cracks today. Is that not correct?

Dr. **Thomas.** I do not know of specific ones but my assumption is that there are and what I was saying is that in response to your question, I agree that we should continue to keep those that may be out there from falling through the cracks if indeed there are some.

Chairman **Wyden.** So I still cannot tell whether you think there are some or there are not. I mean, I think that there seem to be few, if any, standards with respect to nonhospital operating rooms where much of this cosmetic surgery is done. That applies to equipment and the training of personnel. Do you agree with that?

Dr. **Thomas.** What I said in response, is that I do not know of any specifically in my area that are active surgical facilities that are not up to those requirements.

However, it is my assumption that there probably are and I agree completely that we should look at those and seek those out and if indeed we find some then take steps to make sure they are up to standard.

Chairman **Wyden.** I think there are an awful lot of them that are falling between the cracks and I do not think there are, even with the accrediting bodies, a lot of people really looking. I think that is part of the problem. And we are going to want to work with your association and your folks in this regard.

Dr. McCollough?

Dr. **McCollough.** Yes, sir. Might I follow up with that? When we talk about the broad field of facial plastic surgery, or in other words, cosmetic surgery also, we need to look at what the doctor's practice is limited to.

For example, a person doing small dermabrasions on a patient's face, it needs very little sedation and very little anesthesia, it is a small procedure that a person can have done and walk out of the office.

Then we go to the other procedures, such as blepharoplasty and facelift surgery where the patient can be done on an outpatient basis with limited amount of local anesthesia.

Then when we start talking about other types of cases, body plastic cases, abdominal tummy tucks, and larger procedures which require general anesthesia, then you have a whole different set of standards.

So I think that the doctor's office equipment in some way is dictated by the type of practice that he does, whether it is a doctor's office or an ambulatory care facility.

Chairman **Wyden**. Now, I think that is an important point. One of the things that has most concerned me from this inquiry is the amount of out-of-field work that seems to be going on.

We began with Dr. Kamer and I asked about work that was being done on other bodily features. Of course your association deals with several—face and neck, but does not deal with other bodily features.

Dr. **McCollough**. I was not implying that it was our members, the facial plastic academy's members, that were doing tummy tucks or out-of-field surgery.

My point was that as far as ambulatory or outpatient facilities in general are concerned, I think that we must look at the scope of the surgeon's practice within that facility as well.

Chairman **Wyden**. One last question. I guess this would be appropriate for the two presidents, the outgoing and the incoming. Either one can take it.

Why don't we ask you, Dr. Kamer? Do you think that it is time to set up enforceable standards for the nonhospital operating facilities?

Dr. **Kamer**. The word enforceable bothers me. Medicine has always been practiced on a high level. We have today a unique situation. Ambulatory surgery has been around about as long as there has been surgery.

The original facelifts were done in doctors' offices before hospitals became the base for all surgeries. The doctors have done, I think, a pretty good job historically in policing themselves. Yes; there are problems. There are problems in every field.

Today, as we enter a new era, in a way, of subspecialization, superspecialization, so that the patient gets the best, hopefully the best medical care in that particular field that they can get, ambulatory surgery has become a very important part of this type of surgery.

Each one of the societies that you have heard today have credentialing types of bodies that they back to credential outpatient surgical facilities.

We in the American Academy of Facial Plastic and Reconstructive Surgery are members of the AAAHC that you have heard about today. General plastic surgeons have their own peer review.

The Joint Commission for Hospital Accreditation also now has an ambulatory accrediting body.

Chairman **Wyden**. These are all voluntary?

Dr. **Kamer**. Peer review, ambulatory surgical bodies that accredit and in a way credential.

Chairman **Wyden**. They accredit the facility?

Dr. **Kamer**. The facility.

Chairman **Wyden**. So let us just take your members.

Dr. **Kamer**. OK.

Chairman **Wyden**. Because I think that is all we can deal with here. Of your members, are essentially all their outpatient facilities accredited by someone?

Dr. **Kamer**. All of them are not.

Chairman **Wyden**. What percentage are accredited?

Dr. **Kamer**. I do not know the exact percentages, but I can get them for you.

Chairman **Wyden**. Would it be 10 percent, 50 percent, 30 percent?

Dr. **Kamer**. I do not know the exact percentages.

Chairman **Wyden**. Do you not think that is an important issue, doctor?

Dr. **Kamer**. I think the most important issue is the fact that most all of our members who do surgery in an ambulatory setting do it well and do it with high standards. Those standards are set not only by the AAAHC that we adhere to but by our own society and the people who are members of our society, and there is a lot of peer pressure within our academy to maintain those high standards.

Chairman **Wyden**. Let me ask if any of your associates know the answer to that question.

Dr. Cook, do you have any idea what percentage of your members have their facilities accredited by somebody?

Dr. **Cook**. No, sir, I do not. I know there is a very large number. I know that we strongly encourage it. We have continued courses on it and we have been strongly active with the AAAHC to provide that certification because that certification also does imply active peer review, as you may know.

So I think it is important for that reason as well, that we have peer review outside the operating room. I am as concerned as you are.

I do not know the number who are either certified or applying for certification.

The certification process takes about a year from the time you begin to compile your statistics and figures. It is quite laborious.

Chairman **Wyden**. Do you think half your members?

Dr. **Cook**. Half the members who are doing outpatient operative surgery outside the hospitals? I would think so. I hope so. I really do not know a study, though.

Chairman **Wyden**. I hope so, too. I am going to hold the record open on that point.

I mean, I will tell you. I take the view that if you can get voluntary action, that is always preferable. But I consider that a very important issue that I just asked about: what percentage are actually part of some voluntary accreditation program with respect to facilities.

You all have said it is a large number and you hope it is a large number and the like. But as of today, unless someone wants to add anything else on this panel, we do not know. I think that is one of the things that is important about a voluntary program. It has to mean something and people have to know that you need to belong and that there is a high level of participation that is expected.

We will hold the record open on this point and would like that information.

Dr. McCollough. Congressman Wyden, may I insert one thing?

Chairman Wyden. Sure.

Dr. McCollough. I hope that we do not get regulation. I think that we should try to uphold the standards within our organizations and encourage our members to practice good medicine, and put pressure on the ones who do not to clean up their act or to get out.

Now, regulation bothers me, and I think bothers anyone who loves the free-enterprise system, because the question then comes as to who is going to do the regulating.

We have seen examples all day long here today where if you give the ball to one group, there is going to be unfair trade practices, at least if not committed, very closely bordered upon.

So let us make sure that as we talk about this, that if anything comes out of this, that it is fair and that it is open to everyone and that it does not set up another opportunity for any type of monopolistic activities.

Chairman Wyden. I think that is an important point. I think frankly, that there is going to be a need for Federal initiatives; I think there is going to be a need for State initiatives; and I think there will be a need for private initiatives.

At the Federal level, it is a question of dealing with some of this advertising. Frankly, I just think it is out of bounds. I think it is extreme. Every group that came before us today basically said that they thought it was extreme and out of bounds, except yourselves. I understand that you have a difference of opinion on this.

Second, it seems to me there are a number of things that voluntary associations can do and we have talked about a couple of them with your own organization. Then I think there are some things the States can do to try to sort through some of these specialties and various affiliations and develop something that could make some sense with the consumers.

So I do not think anyone is talking about rushing out to pass a bucket full of regulations, particularly at the Federal level.

We will be working with you. Unless you would like to add anything—and I see Dr. Thomas wishes to—we will excuse you, before you cannot even find a restaurant open.

Dr. Thomas. Just briefly, two comments. One has to do with the type of outpatient facility that our membership utilizes. I also do not know specific numbers, but I do know that the great majority of our membership do their surgery in a hospital-based situation and it should not be implied that most of our people are in a freestanding surgical situation where they are not reviewed. They are highly and perhaps even overly regulated in the hospital setting.

Of those who then do have a free standing facility of some sort, then I would agree that most of those or at least a large percentage of them are affiliated with the AAAHC. But the great majority of our people are hospital-based surgeons in terms of the work that they do and are regulated through that means.

Chairman **Wyden**. I appreciate your making the point, and that is certainly a level of protection that is important.

Dr. **Thomas**. Second, it has to do with one final comment that I feel the need to make in terms of advertising, and that has to do with that sort of deceptive advertising that we bounced back and forth all day. In my area in St. Louis, MO, we do not have a lot of medical advertising certainly as compared to the Coast for example. But of that advertising that is there, what I see as misleading is that the majority of it is done by general plastic surgeons. The misleading part is that invariably it implies and occasionally if not through advertising but through media pseudo-advertising statements that they are the only and the best qualified to do plastic surgery procedures. That is very misleading.

I think that in my view that the standard for facial plastic surgery is the well-trained facial plastic surgeon who has gone through the process that we have described. To say otherwise through advertising or through other media contacts indeed is deceptive and indeed is misleading.

Chairman **Wyden**. We will recognize the minority at this point.

Mr. **Russinoff**. Thank you very much, Mr. Chairman. Gentlemen, on behalf of Congressman Broomfield, welcome to the subcommittee. I will address my questions to you, Dr. Kamer, since you are the president.

I wonder if you can give me a rough percentage or a rough figure regarding unsuccessful operations which have ended in litigation performed by doctors affiliated with your academy?

Dr. **Kamer**. I really could not provide that information for you, but I would think that it would be extremely low.

Mr. **Russinoff**. We are talking about maybe 1 percent?

Dr. **Kamer**. I would think.

Chairman **Wyden**. If the gentleman would just let me pursue this as it is an important area.

Do you have a list of the number of malpractice actions that have been either filed or settled in some way or another against your members, Doctor?

Dr. **Kamer**. We do not keep lists of malpractice items that have been filed against our members. That list I am sure that you can get from any State legal agency. I think that they have an agency in each State that provides those lists, and you can obtain those lists. But truly in answer to your question, I would stick to my answer.

Chairman **Wyden**. Do you have a list of actions settled?

Dr. **Kamer**. We do not have those lists, Chairman Wyden.

Mr. **Russinoff**. It would be safe to assume that nobody in this room believes that incompetence and malpractice should go unpunished. The horrible stories that we heard and the pictures that we have seen really demonstrate the need for effective legal resource.

I wonder though if you would comment on the testimony of our first two witnesses with regard to procedure and credentials.

Dr. **Kamer**. Procedures and credentials?

Mr. **Russinoff**. Of the doctors who performed the surgery on Ms. Brown and Ms. Palso.

Dr. **Kamer**. From what I understood, and this is the first that I heard of their sorry plight, that one of the patients was operated on by a board-certified general plastic surgeon, and the other by a cosmetic surgeon I believe. So there certainly is no board that has a monopoly on poor results. There are none of us, and I think that Dr. Gorney said it very well today, that there are none of us who perform surgery, that every surgical procedure has within it an inherent risk and complication.

All of the patients who undergo these surgeries today are to be understood to have a complete knowledge of those risks and complications before undergoing the surgery, and that is part of the surgeon's duty to do in this day and age.

Mr. **Russinoff**. Thank you, Doctor. One more comment. The issue of peer review was brought up during the last panel.

Has your academy or its board established any type of review mechanism at all?

Dr. **Kamer**. We are not a credentialing body. That would have to be done and is done by our own credentialing bodies.

Mr. **Russinoff**. Then just generally, its educational function. What specific methods does the academy employ in order to facilitate the knowledge and skill of its members?

Dr. **Kamer**. To give you an example, this year alone we have helped train over 4,000 surgeons from all over the world in our 40 some-odd seminars, courses and workshops on facial plastic surgery. As an aside, the last rhinoplasty course was given by Dr. Simons in Florida this past December. We had 400 and some-odd attendees representing about 25 countries from all over the world.

We have been involved in this type of educational pursuit from our inception, and that is why we are here. I think that we have done a pretty good job.

Mr. **Russinoff**. I have no further questions, Mr. Chairman. Thank you again.

Chairman **Wyden**. I thank the minority. Let me thank all of you. We are particularly pleased that Dr. Cook is going to be the incoming president. We will look forward to working with you, Doctor, and all of your colleagues. Let me thank you again for your patience.

We are now teetering on the verge of the longest hearing that I have been involved in in my time in Congress, and there is one panel to do. I want to thank you for your patience, and we will look forward to working with you. Dr. Cook, you have a safe flight home.

Dr. **Cook**. Thank you, Chairman Wyden.

Chairman **Wyden**. All right. Dr. Carlton Carpenter, Baton Rouge, LA; Dr. G. Thomas Jansen, Little Rock, AK; and Dr. Edward Krull, Detroit, MI.

Gentlemen, you are aware of our rules, and it is our custom to swear the witnesses. If you would raise your right hand.

[Whereupon, the witnesses were duly sworn.]

Chairman **Wyden**. Gentlemen, we will make your prepared remarks a part of the record in their entirety. We thank you particularly for your patience. If you could summarize in 5 minutes or so your principal views, that would be helpful. We will get your complete remarks into the hearing record as you have submitted them today.

TESTIMONY OF DR. G. THOMAS JANSEN, PAST PRESIDENT, AMERICAN ACADEMY OF DERMATOLOGY, LITTLE ROCK, AK; ACCOMPANIED BY: DR. EDWARD A. KRULL, PAST PRESIDENT, AMERICAN SOCIETY FOR DERMATOLOGIC SURGERY, DETROIT, MI; AND DR. CARLTON L. CARPENTER, PAST PRESIDENT, AMERICAN SOCIETY FOR DERMATOLOGIC SURGERY, BATON ROUGE, LA

Dr. JANSEN. I am Dr. Jansen, and I will make the only comments today and perhaps do it in a short period of time. I am a dermatologist in private practice in Little Rock, AK, where I have practiced for 33 years. I am the immediate past president of the American Academy of Dermatology, and past president of the American Board of Dermatology.

To my right is Dr. Edward A. Krull, chairman of the department of dermatology at Henry Ford Hospital in Detroit, MI, and a director of the American Board of Dermatology. To my left is Dr. Carlton Carpenter, clinical professor in the department of dermatology, Louisiana State University School of medicine. Both Dr. Krull and Dr. Carpenter are past presidents of the American Society of Dermatologic Surgery.

We are here today on behalf of the American Academy of Dermatology, a national medical and surgical organization representing 98 percent of American dermatologists, and our membership is over 7,000. We are also representing the 2,000 members of the American Society of Dermatologic Surgery, and we appreciate the opportunity to appear before you today.

Members of the academy and of the American Society of Dermatologic Surgery share your concerns that cosmetic surgical procedures be performed in appropriate settings by qualified physicians. This includes providing patients with all the information they need to make an informed judgment about their cosmetic surgery.

In our previously submitted testimony, we discuss what a dermatologist is, define dermatologic training, and also the training for dermatologic surgery. I will abbreviate this testimony for the three of us in as short a period of time as I can. We appreciate you including our entire testimony in the written document.

A dermatologist is a physician specializing in the prevention, diagnosis, and treatment of benign and malignant disorders of the skin and related tissues. Since dermatologists are specialists who are oriented by an organ system rather than a diagnostic or treatment modality, we use many diagnostic procedures including microscopic, microbiologic examinations of the skin and its secretions, and our treatment methods include externally applied, injected, and internal medications, selected x ray and ultraviolet light therapy, and a range of surgical procedures.

Dermatologists therefore are singularly qualified to advise in the care of normal skin and to make diagnoses and administer treatment for all skin diseases, skin manifestations of internal disease, and sexually-transmitted diseases. In addition, dermatologists have had extensive training and experience in the management of skin cancers, moles, and other skin tumors, and in the use of various techniques for the correction of cosmetic defects of the skin.

Dermatology residency training is supervised by the Residency Review Committee for dermatology and the Council on Medical Education of the AMA. The plastic surgeons earlier went into a list of the vigors of that type of credentialing. Ours would be exactly the same, and I will not repeat them.

We have 105 approved residency programs in dermatology, providing residents with broad-based clinical training and experience in the direct care of dermatologic patients. This includes hospital care. A minimum of 4 years of residency training is required to assure this knowledge, and many of those who apply for residency programs in dermatology have had other post-graduate training before they apply for the dermatology residencies.

Upon completion of the structured courses of study, candidates apply for an examination by the American Board of Dermatology. The board's primary purpose is to protect the public interest by establishing and maintaining high standards of training, education and qualification of physicians rendering care. After passing the examination, dermatologists are called diplomates of the American Board of Dermatology.

The point should be made that beginning in 1991 that the certificate issued by the American Board of Dermatology will be time limited. Therefore, diplomates will be required to renew their qualifications periodically through a process of examination and evaluation.

Dermatologic surgery is a discipline which deals with the diagnosis and treatment of conditions of the skin, hair, nails, and mucous membranes, and adjacent tissues using various surgical modalities. Techniques employed by dermatologic surgeons include those that accomplish tissue ablation and lesion removal, primary closure, adjacent tissue transfers, and tissue augmentation. These include but are not limited to excision and closure, dermabrasion, hair transplant surgery, soft tissue augmentation, grafting, and liposuction.

Most commonly these procedures are most effectively and efficiently performed in an outpatient setting using local anesthesia almost exclusively for the majority of these procedures. Under special circumstances however, they may be performed in a hospital operating environment.

The American Society for Dermatologic Surgery has developed a core curriculum for dermatologic surgery in residency programs, and surgical case logs are used throughout the residency during the process of board certification and during continuing medical education programs to verify their training experience. Surgical training in dermatologic residencies is extensive, and dermatologic surgeons are not restricted to the use of specific diagnostic or treatment techniques since they focus upon the entire organ and its problem.

Board certified dermatologists are not plastic surgeons, they are not cosmetic surgeons, but they are specialists in the medical and surgical treatment of cutaneous surfaces. They do, however, share a number of areas of expertise with board certified plastic surgeons, otolaryngologists, and in some cases general surgeons.

A large number of procedures utilized in dermatologic surgery such as liposuction, cryosurgery, chemical peels, dermabrasion, soft tissue augmentation, and laser surgery were developed primarily or significantly advanced by dermatologists. Our written testimony discusses this history in great detail.

In your letter of invitation, you asked a number of questions which have all been responded to in our written testimony, and I will not repeat them at this time. However, we do express our concern about appropriate regulation of outpatient surgical pavilions, and the American Society of Dermatologic Surgery is addressing that issue at this present time. The American Academy of Dermatology is also working on guidelines for appropriate standards of care, and they relate to surgical as well as the medical interests that we have.

We also are concerned about advertising. I think that if we look at the bulletin board that very few dermatologic surgeons are listed, but we do know that some of our members who do dermatologic surgery are involved in advertising. My personal conviction as an older practitioner is that many of these techniques are not appropriate.

You have expressed concern about peer review and how that can be regulated, and we share your concern that the Congress must take additional steps to protect and participate in this process if it is to be effective. Subsequently we must develop an effective peer review process for office-based procedures. As I mentioned, that is under way because of the importance of this issue.

I am going to conclude here with a thanks for your invitation for us to appear and to speak before you with a reiteration that dermatology is primarily an office based practice. There was one suggestion by the plastic surgeons today that was of some concern to us which dealt with credentialing through hospitals to do procedures in our office.

I have done dermabrasive surgery for 35 years, and should I now be obligated although I have that credential in Little Rock to have that in a hospital setting to do it in my office. You would find that in the country that not all dermatologists who are qualified through that technique would be permitted to get hospital credentials with ease. So I think that there are many procedures that we are skilled at that through that formula that was proposed for otolaryngology and dermatology that it would not provide us with an opportunity to do so. I thank you for the opportunity to testify.

[Dr. Jansen's statement may be found in the appendix.]

Chairman **Wyden**. Doctor, thank you for your patience, and let me ask two things. One, the staff would like to pose some questions to the association in writing simply in the interest of time. Would the association have any objection to that?

Dr. **Jansen**. Absolutely.

Chairman **Wyden**. Let me just quickly then ask you a couple of the same questions that I asked the various other associations, again with the idea of trying to move beyond one discipline against another.

Is it your view, Dr. Jansen, that overall that the number of charlatans and quacks that are moving into the cosmetic surgery field is growing?

Dr. JANSEN. I have listened to your question all day, and I have listened to the various answers that have been given, and my hesitancy would have been the same. I think that it is very difficult for us to come up with percentages on that. We know that people can say that they do certain things in a practice environment separate from an institution.

I think that people now have a much greater consciousness of self-image, beauty, and youth. That plus the advertising that you see I am sure is drawing more people into getting that type of care. Because of this lack of regulations, I think that there probably are, but I have no information statistically to prove that.

Chairman WYDEN. Doctor, do you think that the advertising, the misleading and deceptive advertising, is widespread, is there a significant amount of it?

Dr. JANSEN. I would ask my associates, since they did not give testimony, to share in the answers if they would like to, to give them an opportunity. Dr. Krull.

Dr. KRULL. I certainly perceive a greater advertising in the yellow pages and our local newspapers, and most of it seems to deal with cosmetic surgery. However, I do not find that as an isolated issue. I am not saying that there does not need to be some voluntary changes. Hospitals are advertising their excellence and hospital groups are advertising against each other. So we are seeing this throughout the medical field and probably through other fields as well. But certainly, it seems to be the case in cosmetic surgery.

Chairman WYDEN. It seems to be the case that there is a growing amount of misleading and deceptive advertising?

Dr. KRULL. Yes; I think so. I would like to address the question that you asked before, because I would like to pull that into the category of peer review. It is a little different from what we have been dealing with. I listened to the two patients today. One is in suit and is supposed to have been mistreated by her physician probably with some defective care, and the other one we are told may have been under the influence of drugs at the time or at least that was suggested. It is unclear to me at least that the person——

Chairman WYDEN. Doctor, I am sorry, you said that the patient was under drugs?

Dr. KRULL. I am sorry. The physician was subsequently found guilty of a felony I think of using drugs.

Chairman WYDEN. That is what I believe the witness said.

Dr. KRULL. That is what the witness said. But what I would like to say is that basically we are talking about bad doctors perhaps. This is peer review and it is not some of the issues that we are dealing with here. Peer review is a difficult problem because of the malpractice and medical legal issues. If we need any help from Federal agencies, certainly it is to strengthen our ability to do proper peer review on physicians who may be fraudulently advertising and not practicing a good quality of medicine.

Chairman WYDEN. I do not know if you were here before when we discussed this, because it is an area of special interest to me. I sit, in addition to chairing this subcommittee, on the health subcommittee chaired by Mr. Waxman and was the author of the Health Care Quality Improvement Act that provides legal protection to physicians who blow the whistle on a colleague who they believe is malpracticing. It grew out of a fairly celebrated case in Oregon that went all the way up to the Supreme Court.

But it seems to me that the peer review issue here is a little bit different, and something probably that my bill nor any of the things that have gone before are really going to address. Because first, these are outpatient settings, so that you do not have some of the opportunities for peer review that you would have in other settings.

Second, you have this blizzard of disciplines and affiliations to the point where it is very hard to determine who is really affiliated with who and certifying that they have a particular degree of expertise. I think that that is contributing to the problems of peer review as well, would you agree?

Dr. **Krull.** Yes; and I think that the medical profession has shown historically that in its voluntary efforts that it has done a very good job brought through the Residency Review Committees and the American Board of Medical Specialties. In dermatology, the American Academy is setting up standards of care in liposuction and many other procedures. We have also heard that the American Society for Dermatologic Surgery is developing some guidelines for office based surgery which hopefully will be out in 1989 which can serve as a basis for the things that you are asking.

I think that our medical groups can do it. In dermatology as I look at it, we have come from doing basically smaller procedures which have historically a very safe context. You can look back historically and find that office surgery done by dermatologists has been inherently a safe procedure. As we move into perhaps more extensive surgery, the issues that we are discussing today become far more important. Our American Academy and the American Society for Dermatologic Surgery I think are responsibly addressing them.

Chairman **Wyden.** Do you feel that there is a push by consumers today for more radical surgery? You have mentioned and several others today have talked about more modest procedures and talked about evolving technology and the like. Are consumers today pushing for more radical surgeries, coming to you and other practitioners for that?

Dr. **Krull.** I can only speak for myself and my own group at Henry Ford Hospital. It seems that patients would like to look a great deal differently from what they do. They have a stronger image concern. As such, they may be pushing for more significant surgery than they were a few years ago. Part of that may be fed by the fact that there are procedures now that are able to meet some of those needs.

Chairman **Wyden.** I probably could ask questions of all of you for another half an hour if we had the time and all of us the constitution. But all of you have been very kind to be so patient. We are going to submit some additional questions. Unless you would like to add anything further, we will excuse you at this time.

Dr. **Carpenter**. I would just like to reiterate that dermatologic surgery is basically office based and that many of the cosmetic procedures that are used by dermatologists were developed by them such as dermabrasion, hair transplantation, and SC/CRO therapy. These can safely be done in an office, and we are developing peer review mechanisms to make sure that our facilities are up to standards.

Chairman **Wyden**. Very good.

Dr. **Jansen**. One last comment. I think that as I listen to all of this that it should be clear that many times decisions relevant to life and death situations are occurring in physicians' offices separate from the issues of surgery, either surgery of one type of cosmetic surgery or another. That it is very difficult to control that setting completely. I would hope that you would not limit your concerns about this completely to cosmetic surgery, because I think that there are other issues being made in an office setting that may be of equal or greater importance.

Chairman **Wyden**. You are absolutely right, Doctor, and this subcommittee has looked at a number of those. We have looked at issues for example like medical waste and other not exactly noncontroversial matters in this country. It is clear that there are special problems in outpatient settings which you would not have in hospital settings. So your point is well taken. We thank you for your cooperation and certainly your extraordinary patience. Unless you would like to add anything further, we will excuse you at this time.

Dr. **Jansen**. Thank you.

Chairman **Wyden**. Thus concludes the first of the subcommittee's hearings into cosmetic surgery. We have learned a number of very important things today about the cosmetic surgery field, not the least of which is that cosmetic surgery is a multibillion dollar industry dominated by small businesses.

The consumer has a wide variety of choices that are presented to them. Frankly, what we have heard is that very often these choices are presented in such a way that consumers find it very difficult to determine who is a qualified surgeon, who is a qualified practitioner, and who is not. The choices seem to be blurred in the eyes of some in this country.

There are a large number of medical boards out there and some that perhaps might not fit the traditional definition of medical board, and each claims really now to be the best and to be superior. Consumers are put in the position of having to determine the difference. Is a plastic surgeon the best. That person may have training all over the body. Is a cosmetic surgeon the best. Possibly someone with more experience in a wide variety of specific procedures.

The Federal Trade Commission has made a decision that in effect permits unbridled advertising, and has failed to follow up on some of the really outlandish advertising claims. As a result, consumers find it very difficult in my view to make the best or the most appropriate choices for them.

So it is the Chair's sense as we conclude our first hearing, that patients need and deserve more, deserve more in the way of thoughtful and responsible advertising at the practitioner level, advertising that it seems to me is not always provided. The Federal

Trade Commission should step in when it does get out of bounds and when it does get extreme.

I also think that the voluntary societies can do more to ensure responsible behavior. We have heard several valuable proposed changes today from the professional societies, and we will want to follow up with them in the days ahead.

I think that it is also clear that the States are going to have to take a more activist role in terms of assuring quality assurance, and possibly that would be the appropriate place to try to sort out some of these multiaffiliations and conflicting boards and associations that many practitioners seem to be involved in.

So there is much to do all the way from more aggressive self-policing and self-regulation by the various associations, to working with the Federal Trade Commission to stop outlandish advertising. We will have the Federal Trade Commission at our next hearing. We will see what they are going to do specifically to stop some of the false and deceptive advertising that we have been told about today.

The Chair wants to thank our witnesses, and particularly the staff for an outstanding job over a great many months. The Subcommittee on Regulation today stands adjourned.

[Whereupon, at 5:20 p.m., the subcommittee was adjourned, subject to the call of the Chair.]

APPENDIX

HEARING STATEMENT

UNQUALIFIED DOCTORS AND THE RISKS OF COSMETIC SURGERY

REP. RON WYDEN
BEFORE
THE SUBCOMMITTEE ON REGULATION, BUSINESS
OPPORTUNITIES & ENERGY

APRIL 4, 1989

Good morning. Today the subcommittee begins its first in a series of hearings regarding the health hazards posed by a dangerously under-regulated medical field: cosmetic surgery. This is a relatively new area of small business opportunity, undergoing explosive growth.

Untold numbers of patients seeking the fountain of youth through a face-lift, a tummy tuck or an acid peel, sometimes get more than they bargain for -- suffering infection, stroke and occasionally death following procedures that are advertised as safe, easy and painless. According to the American Society of Plastic and Reconstructive Surgery, 11 deaths have resulted from one procedure alone -- liposuction -- since 1982.

These are the sunrise profit centers of the medical profession, brand-new revenue avenues that are well-traveled by both good surgeons and bad. But too many cosmetic "surgeons" have no formal surgical training. Others using the shield of established professional society logos have little more training in specific cosmetic surgery procedures.

Some of these pseudo-surgeons have realized huge profits in recent years thanks to a laissez faire Federal Trade Commission. The agency became an unwitting accomplice to the physical and emotional scarring of too many patients by failing to protect Americans from misleading advertising and cosmetic surgery hype.

The subcommittee has reviewed hundreds of cosmetic surgery ads, and here are some examples:

"Hi, I'm Carol. If you'd like to know how cosmetic surgery changed my life, call me." The ad pictures an voluptuous woman in a swimming suit. There are no disclaimers regarding the risks of anesthesia, for instance, or the dangers of specific surgical procedures. Nor is there anything about the qualifications of Carol's doctor -- not even his name.

Or, the ad that features swimsuit-clad magazine centerfold Rebecca Ferratti, lounging on sportscar, and saying "So next time you see me draped seductively over a Ferrari you'll know that the true caption ought to read -- 'Body by Smithdeal.'

Smithdeal is her cosmetic surgeon, not her mechanic.

Or, how about "Improve on mother nature. Feel good about yourself. In most cases, surgery is performed on a same day basis."

And then there's: "Easy come, Easy go. Body contouring through liposuction and laser surgery."

The message is consistent. It's easy. It's safe. It's painless.

Once the province of the rich and famous, elective cosmetic surgery has moved from the plush salons of Southern California to Main Street, U.S.A. Riding a promotional wave of unbridled, often-misleading, and sometimes false advertising, the masters of the miracle make-over prey on the insecurities of all of us -- from 18 to 80.

This is already a multi-billion-dollar-a-year business growing larger every day. And why not? Consider the most popular procedure -- liposuction, the surgical removal of fat by a machine not unlike a vacuum cleaner. A cosmetic surgeon can buy $4,000 worth of equipment on Monday morning, do two procedures on Monday afternoon, and make money all day Tuesday.

The chair believes that while some cosmetic surgeons have great skills, too many are hucksters who misrepresent their inadequate training to make a fast buck. Based on the subcommittee's efforts, including the review of thousands of documents and interviews with hundreds of doctors, patients and regulators, the chair concludes the following:

-- In most states, drivers have to prove they have liability coverage. But in medicine, doctors can practice cosmetic surgery without any insurance coverage at all, and many do.

-- In every state, any medical school graduate with a state license can perform cosmetic surgery. There are no barriers to entry -- public or professional.

-- Across this country, self-declared medical "boards" compete for patient dollars with older, American Medical Association-sanctioned societies. Who's best? The public doesn't know and they can't find out.

-- Traditional peer review of cosmetic surgery is virtually non-existent, since an estimated 95 percent of these procedures are done in doctors' offices, outside of hospitals and the protective eye of surgical review boards.

-- Coast to coast, these office practices are touted as "institutes", "centers", and "clinics" of cosmetic surgery in the more expansive ads. In too many cases, we see one doctor, in a spartan surgical setting, with a skeleton crew. Too often they lack the most basic life-support systems found in the smallest hospital emergency rooms. Neither are we sure that personnel with even the most rudimentary technical training assist in these procedures.

-- Even normal government and private audit systems are absent, since in most instances these surgeries are covered neither by Medicare nor private health insurance.

The Federal Trade Commission had a chance to solve some of these problems in 1976. They began a far-reaching and expensive investigation into the cosmetic surgery field.

The FTC decided that it was time to force competition upon the medical marketplace. They said prices would go down -- and, well, quality of care wouldn't suffer too much. In effect the agency's decision gave the green light to claim-anything-advertising, and short-changed patient safety.

The FTC dropped the ball, and its decision has ill-served both patients and doctors. Patients can't tell who's qualified and who's not. Doctors say they're frustrated in their efforts to weed out the quacks.

When I asked the FTC two months ago why it had abandoned its inquiry into cosmetic surgery, FTC Secretary Donald S. Clark replied in a February 16, letter that "we can't speculate."

I don't know whether that means that they don't know... or that they won't tell us.

I hope that FTC Chairman Daniel Oliver can shed light on this perplexing issue, at our second hearing, on May 2nd.

Two weeks ago, Food & Drug Administration Commissioner Frank Young told the subcommittee that medical fraud in the U.S. costs us as much as $40 billion per year. Obviously, false advertising plays no small part in spreading this kind of snake oil.

We have many doctors, representing many different specialties, prepared to give testimony today. But before they begin, I'd like to bring forward two consumers -- women who have both had cosmetic surgery -- to tell us a few truths about the business that they have learned the hard way.

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MEMORANDUM

DATE: MARCH 27, 1989

TO: CHAIRMAN RON WYDEN

FROM: SUBCOMMITTEE STAFF

SUBJECT: UNQUALIFIED DOCTORS PERFORMING COSMETIC SURGERY: MUST THE "BUYER BEWARE" IN THIS MULTI-BILLION DOLLAR MEDICAL INDUSTRY?

Mr. Chairman, over the last two years, under your leadership the staff has investigated many trends in the medical field and how they are affecting the quality and cost of health care. No trend is more pronounced and widespread than that of more and more doctors operating outside the hospital setting. Although we have found that most in the medical community are honest and ethical, many are not. Whether it be consumers counting on safe, reliable medical testing, infertile couples seeking to have a baby or those seeing lumps and bumps in the mirror, all are highly susceptible to potential exploitation.

The common thread through all the subcommittee's investigations has been (1) inappropriate use and lack of credentials, (2) misuse of medical technologies, (3) no minimum standards for out-patient facilities and (4) false or misleading advertising. Unfortunately, we also found that the government has either been oblivious to these alarming trends or they have chosen to ignore them. The government has abdicated its responsibility, the quality of health care has deteriorated and American consumers has been left to fend for themselves.

No where is this more evident than in the ugly realities of the multi-billion dollar cosmetic surgery industry.

COSMETIC SURGERY BOOM: MEDICINE GOES MADISON AVENUE

Over the last several years, many patients of cosmetic surgery have been seriously injured and some have died following elective cosmetic procedures. It appears that the field is being overrun by less than fully qualified doctors operating with little or no oversight by either government or their peers.

Fully 95 percent of all cosmetic surgery procedures are now done outside of hospitals, in doctors' offices or in limited service clinics.

Based on the staff's six-month investigation, it appears that the government has become an unwitting accomplice by making consistently uninformed and ill-conceived decisions on how to guarantee safe, affordable medical care. The Federal Trade Commission stands alone in having taken one dramatic -- and many say disastrous -- step that has crippled the medical profession and left the American consumer virtually defenseless.

The FTC declared war on the learned professions as it implemented the Federal Trade Commission Improvement Act of 1975. Advertising came to the legal profession -- followed shortly by the medical profession. It first brought "ambulance chasers" into our living rooms during prime time. According to some doctors and lawyers alike, this single act may be a major contributor to our current malpractice crisis.

Then came the medical profession. With its federal court victory over the AMA and two Connecticut medical organizations, the FTC threw open the regulatory door for medical advertising. Not only did it send the message that the FTC would not prohibit the peddling of medicine, it made it virtually impossible for the medical profession to police its own to ensure ethical standards and quality care.

That history shows that the FTC miscalculated badly and dangerously when it opened up medicine to the kind of advertising previously reserved for the ABCs -- automobiles, beer and cigarettes. The only difference is that in doctors' ads, the Surgeon General's warning is missing.

Until then, the medical profession had managed to limit the old "snake oil" salesman approach to medicine. To curb that 19th Century style of false and deceptive advertising, doctors formed societies, established medical specialties and tested and certified members to boards formally recognized by the American Medical Association.

Now, the barn door has swung open and the quacks have waddled out. History has begun to repeat itself.

This should come as no surprise to the FTC. The agency actually anticipated and accepted that there would be serious risks to patients. As one FTC staffer said,

> "I won't deny the fact that some people will go into brain surgery and have consequences that we all don't want. There will be costs -- really serious costs -- but the benefits are that we will know what the hell is going on in the medical marketplace."

The FTC was right. We do know much more about the medical marketplace. We know that most patients take at face value cosmetic surgeons' ads. We know that they think most cosmetic surgery is safe. We know that they think it's safe to have surgery done in doctors' offices, not just in hospitals. We know that they aren't as careful selecting a doctor because they've been led to believe that virtually anyone can do these "simple" procedures and they can do them virtually anywhere. We know that thanks advertising pandering to underestandable interest in our society's preoccupation with youth hundreds of thousands of Americans are having dozens of these procedures. And finally, we know that the FTC's medical marketplace has become a multi-billion dollar industry in the cosmetic surgery field alone.

Unfortunately, we also know that countless patients are being injured. They are being physically and emotionally scarred and they are being financially drained.

Even when potential patients try to be "good medical consumers," they run into a stone wall erected by state and federal governments, medical societies and individual doctors themselves. With a lot of help from the FTC and some in the medical profession, it has become virtually impossible for patients to tell who is a good, qualified doctor and who is not.

And the marked trend toward outpatient surgery has removed the last vestige of accountability for many doctors. No hospital review board verifies the quality of these surgeons' work. No one guarantees whether the "operating room" has even basic life support equipment. No one ensures that the doctor has good, qualified staff to give anesthetic, to monitor the patient and to respond quickly should complications arise.

The frightening result may be that the new back alley of medicine has become the doctor's office itself. We have found that, incredibly, any doctor who manages to graduate from medical school, and receive a state license, can do anything, be anything. Anyone with a medical degree and a state license can do brain surgery, face lifts, breast reductions or enlargements-- even open heart surgery.

This situation exists in every state in the country. But many believe such an environment is far from ethical. Competition has, indeed, come to the medical profession.

WHO'S WHO IN MEDICINE?

Over the years, the "Good Housekeeping Seal of Approval" in medicine has been board certification in a given specialty or area of expertise. But that distinction is murky in cosmetic surgery.

A consumer used to be able to count on a "board certified" doctor having the following qualifications;

- four years of post-graduate medical school;
- three to seven years residency training;
- an unrestricted license to practice; and
- passing a comprehensive medical specialty examination.

But in cosmetic surgery, nearly all boards claim to offer expertise in some procedures. The AMA's American Board of Medical Specialties has approved 23 such boards -- including several claiming to be qualified to do various cosmetic surgery procedures. Thanks to the FTC, however, anyone and any group can create a board, call itself anything and issue certificates suitable for framing. So far, 102 of these self-designated boards have sprung up.

The public is legitimately confused. Not only are individual doctors vying for the public's confidence -- and dollars. Boards themselves engage in what Supreme Court Justice Potter Stewart called "an unseemly rivalry which would enlarge the opportunities of the least scrupulous."

Millions of dollars are spent each year by plastic surgeons, otolaryngologists (ear, nose and throat specialists), eye surgeons and others to convince the public that they are the best. Inter-specialty rivalry has doctors grasping for the golden ring of cosmetic surgery. MacDonalds, Burger King and Wendy's have nothing over these desperate doctors -- many of whom feel that they can't afford not to advertise. Virtually all of them take credit for inventing and perfecting each procedures. And all of them proclaim that the bottom line is patient safety.

"BRAND X" OR "GRADE A"? -- ANATOMY OF AN AD

In an effort to see whether the nation was being blanketed with false, deceptive and misleading advertising, the staff collected and reviewed thousands of sample ads. The Congressional Research Service surveyed six major city magazines for the year 1988, specifically at the subcommittee's request. The subcommittee also analyzed yellow page advertisements for eight other metropolitan markets. Additionally, newspaper ads were reviewed on a random basis.

That review suggests that what had become a way of life for the people of Rodeo Drive in Beverly Hills, has migrated to Main Street, U.S.A. We found the Madison Avenue approach to medical care. The staff has concluded that the field of cosmetic surgery is practicing "Yellow Page Professionalism."

After interviewing numerous doctors from many specialties, lawyers and consumers, the subcommittee staff believes that ads which state, lead one to conclude and purposely omit information are attempting to mislead the consumer. The staff believes that such advertising falls clearly within the jurisdiction of the FTC and should be reviewed by the Commission for appropriate legal action.

The staff has identified the following type of cosmetic surgery ads that should send a red warning flag up to the consumer and the FTC. Advertisements that:

- contain promises about the physical results of surgery;
- contain statements about the surgical procedure;
- contain claims about the innovative character of an operation;
- contain false claims about the physician or his or her staff;
- contain so-called "before and after" photographs, with the "after" photograph posed in a more favorable angle and lighting;
- show the results of one patient's experience or one person's testimonial to apparently imply and mislead other people to conclude that anyone having the same operation can and should have similar results;

- utilize truthful information in a manner that may mislead potential patients as to the qualifications of the advertising physician. An example is one physician who included his membership in the AMA as part of his qualifications. Membership in the AMA is not a function of professional skill;
- assert that a physician is a qualified as a "board certified cosmetic surgeon" when no board of that title is recognized by the American Board of Medical Specialties;
- claim board certification when they are actually certified in other specialties having little or nothing to do with the cosmetic surgery procedures being performed;
- advertise credentials, perhaps impressive to lay persons but medically meaningless, including authorship of articles published in obscure medical journals;
- state doctor inventions of surgical instruments;
- state special residency training and expertise;
- claim state-of-the-art facilities and invite visits by patients who want to make comparisons. Most potential patients have no way to judge its adequacy and medical necessity, and often are mislead by the "Tokyo effect" of fancy gadgets with lights, bells and whistles to suggest safety and state-of-the-art technology;
- lure people into an office by providing something free. The staff believes such ads lead to "hard sell" techniques used once the patient arrives in the office;
- emphasize the reasonableness of fees and the easy financing that's available;
- utilize photographs of attractive models who in most cases have little or no relationship to any cosmetic surgery actually performed on on the model. The staff believes that psychologically appealing advertising appears to minimize the potential health risks of these surgical procedures; and
- fail to mention even the name of the operating surgeon.

WHO'S WATCHING THE STORE?

> "Freedom of speech doesn't give a person the right to yell "fire" in crowded theater, Supreme Court Justice Oliver Wendell Holmes Jr. once noted. Nor should it give con artists the right to promote health frauds through ads in print or on the air. Yet, health fraud lives and even thrives, in no small part because of successful advertising."

One would hope that this warning would be the primer for FTC attorneys charged with protecting the public from false, deceptive and misleading ads -- and the resulting risk to their health. Instead, that quote from "Critiquing Quack Ads" is from a Food and Drug Administration advisory to consumers.

The FTC is still no where to be seen. FDA Commissioner Frank Young told this subcommittee just last week that medical quackery is alive, well and thriving, estimating the costs to consumers at between $10 billion and $40 billion per year. Apparently his agency -- which has little control over false advertising -- is more aware, more concerned and more aggressively trying to protect the public than the FTC -- with its virtually unlimited authority to prohibit such exploitation.

PURPOSE OF SUBCOMMITTEE HEARINGS

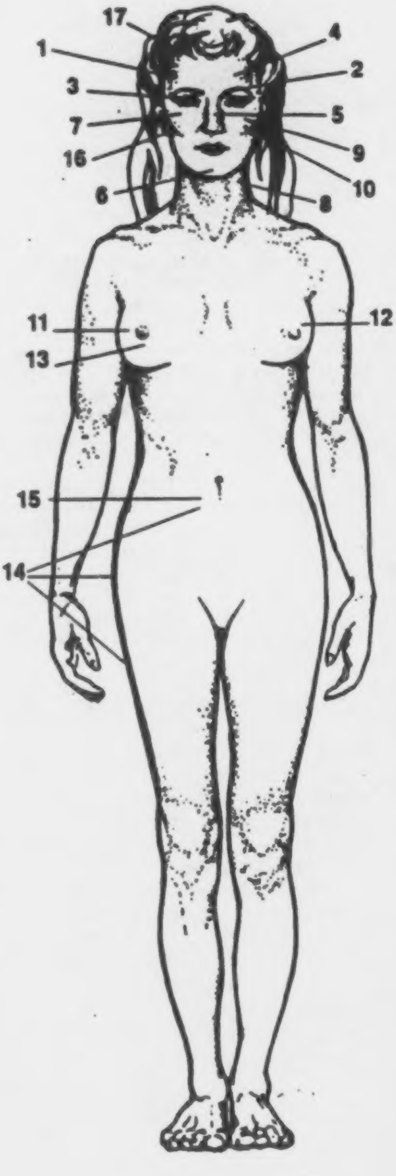
Some say the issue is quality. Some say it's dollars and cents. Some say it's a complicated turf battle pitting one medical specialty against another. In any case, the FTC is merely sticking its bureaucratic head in the sand, leaving the hapless medical consumers to fend for themselves. Witnesses before the subcommittee's first hearing on April 4, will include victims of botched cosmetic surgery and representatives from the medical community. Witnesses at the second hearing, on May 2, will include the FTC, the FDA, officials from state licensing and quality assurance boards and medical accrediting societies.

	FACIAL PROCEDURES	COST	RECOVERY TIME
1	Face Lift: Skin and facial muscles are tightened and excess skin is removed.	$2,500-8,000	1½ - 2 Weeks
2	Brow Lift: A section of skin is removed and the eyebrow is lifted.	$1,000-2,000	1 Week
3	Eyelids (upper/lower): Bags, folds and sags in the eyelids are removed.	$2,000-4,000	3 - 10 Days
4	Forehead Lift: An "upper-face" lift where skin is tightened and excess is removed.	$2,500-4,500	1½ - 2 Weeks
5	Nose Correction: Length and shape of a nose are remodeled to conform to proportions of the face.	$2,000-6,000	1 Week
6	Chin Augmentation: Enlargement of a small or recessed chin is achieved by insertion of an implant.	$1,000-2,000	1 Week
7	Cheekbone (Implants): Cheekbones are "defined" by insertion of an implant.	$1,500-2,500	1 Week
8	Neck Contouring (Liposuction): Fat cells are removed from neck for contour.	$1,000-1,500	1 Week
	SKIN TREATMENT		
9	Chemical Peel: The outer layer of skin is chemically "burned" to remove fine lines or acne scars.	$2,000-4,500	2 - 3 Weeks
10	Dermabrasion (Sanding): Skin is "sanded" to remove fine lines or acne scars.	$1,000-3,500	2-3 Weeks
	BODY SCULPTURING		
11	Breast Augmentation: An implant is placed in the breast to enlarge size or improve shape.	$2,000-4,000	1 - 2 Weeks
12	Breast Reduction: Large breasts are reduced in size and made firmer by the removal of excess tissue.	$3,000-6,000	2 - 3 Weeks
13	Breast Lift: The nipple is moved up and breast skin is brought down for support.	$1,000-4,000	1 - 2 Weeks
14	Liposuction (Fat Reduction): Fat is suctioned from the thighs, hips, abdomen, knees, face, and under the chin.	$1,500-6,000	2 Weeks
15	Tummy Tuck: Loose skin is tightened and excess is removed.	$2,000-6,000	3 - 4 Weeks
	OTHER PROCEDURES		
16	Ear Correction: With protruding ears the cartilage is reshaped and "pinned back."	$1,000-4,500	1 Week
17	Scalp Reduction: Non-hair bearing skin is removed.	$1,000-5,000	1 Week

- Prices may vary depending on geographic location and/or severity of the condition.
- Recovery times are average. Individual recovery times may differ.

American Academy of Cosmetic Surgery

1-800-221-9808



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- fail to mention even the name of the operating surgeon.

"To see how I looked before Cosmetic Surgery, wrinkle this page."

Until a few years ago, facelifts that tightened the skin were the only available remedy for aging. However, many people who've had this done complain of the "pulled", unnatural look.

In the last few years, Dr. Richard Ellenbogen has developed, tested and proven a safe, natural looking, much improved alternative to the classical facelift.

This new surgical technique tightens aging muscles and sculpts unwanted fat deposits in the cheeks, neck, and the corner of the mouth that causes you to look older. This allows for a very natural appearance.

You may have seen Dr. Ellenbogen discussing this, and other face rejuvenating techniques, on *The Phil Donahue Show, Cosmopolitan, Time, Newsweek, The Wall Street Journal or USA Today.*

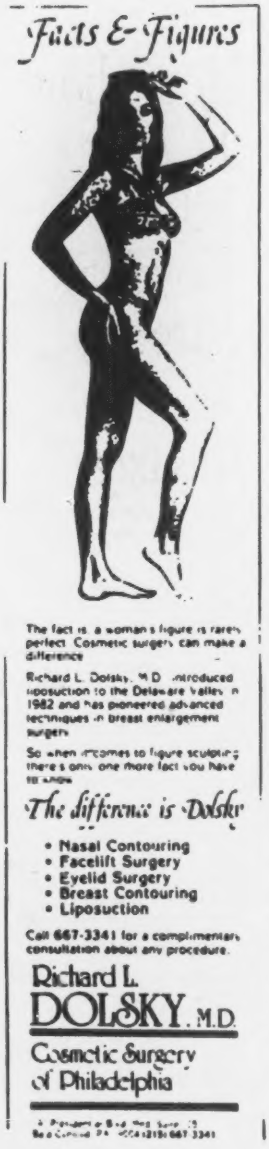
If you are tired of staring wishfully into the mirror and you'd like more information, give us a call.

It could change the way you look at life. And change the way people look at you.

Actual Patient Photo

RICHARD ELLENBOGEN, M.D.

Certified Diplomate American Board of Plastic Surgery
[illegible] Sunset Blvd · Suite 202, Los Angeles, CA [illegible]
(213) 276-3183



Facts & Figures

The fact is, a woman's figure is rarely perfect. Cosmetic surgery can make a difference.

Richard L. Dolsky, M.D. introduced liposuction to the Delaware Valley in 1982 and has pioneered advanced techniques in breast enlargement surgery.

So when it comes to figure sculpting there's only one more fact you have to know.

The difference is Dolsky

- Nasal Contouring
- Facelift Surgery
- Eyelid Surgery
- Breast Contouring
- Liposuction

Call 667-3341 for a complimentary consultation about any procedure.

Richard L.
DOLSKY, M.D.
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of Philadelphia

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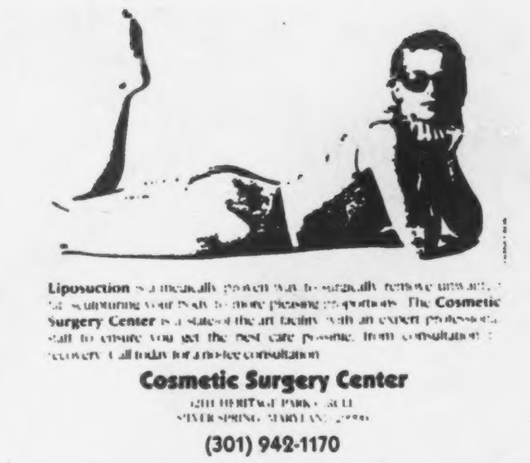
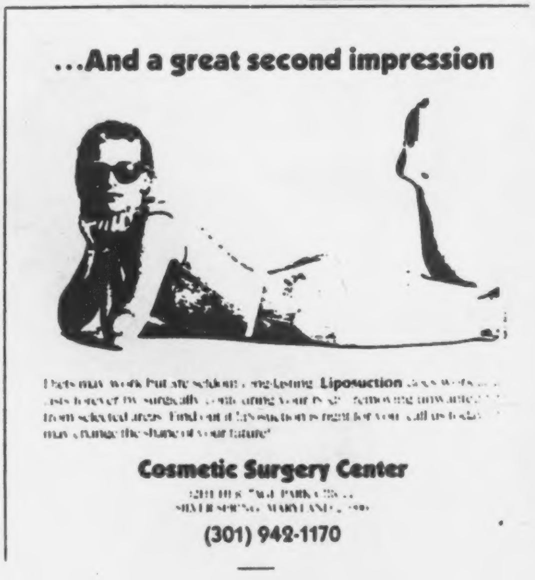
Bala Cynwyd, PA 19004 (215) 667-3341



Liposuction is a medically proven way to surgically remove unwanted fat, sculpturing your body to more pleasing proportions. The **Cosmetic Surgery Center** is a state-of-the-art facility with an expert professional staff to ensure you get the best care possible, from consultation to recovery. Call today for a no-fee consultation.

Cosmetic Surgery Center
12111 HERITAGE PARK CIRCLE
SILVER SPRING, MARYLAND [illegible]
(301) 942-1170



...And a great second impression

Diets may work but are seldom long-lasting. **Liposuction** does work and lasts forever by surgically contouring your body, removing unwanted fat from selected areas. Find out if Liposuction is right for you. Call us today. It may change the shape of your future!

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SILVER SPRING, MARYLAND [illegible]
(301) 942-1170

"If you'd like to know how cosmetic surgery changed my life, call me."

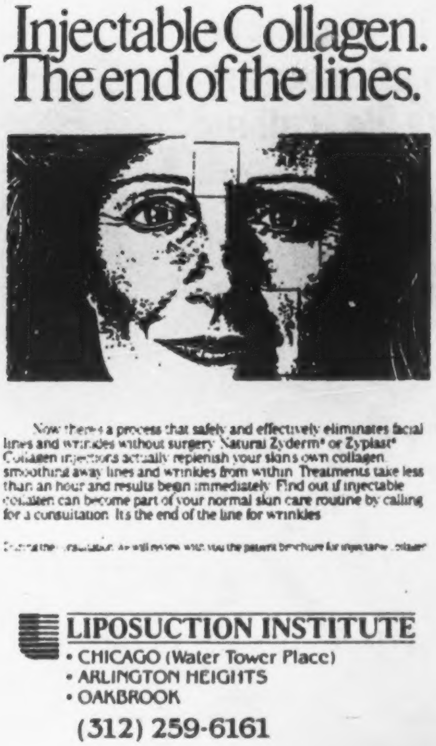
"Hi! I'm Carol. Cosmetic surgery has really changed my life. After having four children, it's nice to feel good about myself again. I was so pleased with the way my surgery simply made me feel. I thought other women would want to know what my experience was like. From consultation to recovery, the caring staff at the Cosmetic Surgery Center was great. And the state-of-the-art facility assured me that I'd get the best care possible."

"If you'd like to talk, call me at 301-942-1170."

Cosmetic Surgery Center

12111 HERITAGE PARK CIRCLE
SILVER SPRING, MARYLAND 20906

(301) 942-1170



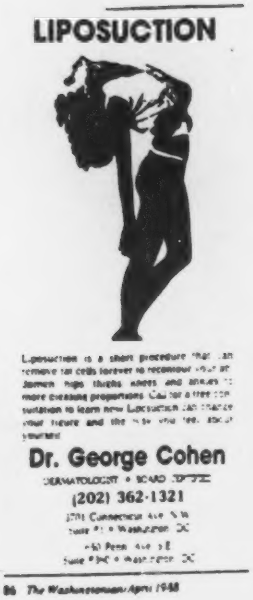
Injectable Collagen.
The end of the lines.

Now there's a process that safely and effectively eliminates facial lines and wrinkles without surgery. Natural Zyderm® or Zyplast® Collagen injections actually replenish your skin's own collagen, smoothing away lines and wrinkles from within. Treatments take less than an hour and results begin immediately. Find out if injectable collagen can become part of your normal skin care routine by calling for a consultation. It's the end of the line for wrinkles.

During the consultation, we will review with you the patient brochure for injectable collagen.

LIPOSUCTION INSTITUTE
- CHICAGO (Water Tower Place)
- ARLINGTON HEIGHTS
- OAKBROOK

(312) 259-6161

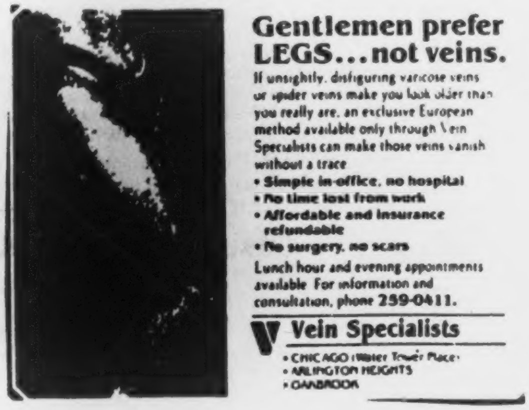


LIPOSUCTION

Liposuction is a short procedure that can remove fat cells forever to recontour your abdomen, hips, thighs, knees and ankles to more pleasing proportions. Call for a free consultation to learn how Liposuction can change your figure and the way you feel about yourself.

Dr. George Cohen
DERMATOLOGIST • BOARD CERTIFIED
(202) 362-1321
[illegible] Connecticut Ave. N.W.
Suite [illegible] • Washington, DC
[illegible] Penn. Ave. S.E.
Suite [illegible] • Washington, DC

86 *The Washingtonian/April 1988*



Gentlemen prefer LEGS...not veins.

If unsightly, disfiguring varicose veins or spider veins make you look older than you really are, an exclusive European method available only through Vein Specialists can make those veins vanish without a trace.
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- OAKBROOK

The Six Most Important Questions to Ask When Considering Cosmetic Facial Surgery

*H*ow can you make the right decision when considering cosmetic facial surgery? Here are key questions you must answer before deciding, as suggested by *The Consumer's Guidebook to Cosmetic Facial Surgery*:

---

1. Are you a good candidate for cosmetic facial surgery? Many factors such as your general health, skin quality, life style and motivation must be considered. Only a consultation with an experienced, qualified specialist can help you determine your candidacy.

---

2. How specialized is your prospective doctor? Don't be shy about asking which procedures your prospective doctor specializes in or performs most frequently. A high degree of specialization is extremely important. Ask to see the doctor's professional biography. Some additional credentials to check include board certification, additional "fellowship" training exclusively in cosmetic facial surgery, and teaching and research responsibilities.

. What should you expect from your consultation? The purpose of the consultation is for you to learn and to have your questions answered completely. Your meeting with the doctor should be unhurried, relaxed and comfortable. Books and other reading material should be available to you. Learn as much as you can. The more informed you are, the better your decision will be. It's a matter of being a smart consumer.

---

4. What results can I expect? Before and after photographs of a variety of patients should be available to you. These can give you a sense of the doctor's artistry. Of course, the best results look natural. It also helps to meet and speak with people who have had the same procedure that you are considering. You can often better understand the process, expectations, and results through the experience of others.

Therefore, fees vary with each individual. You need to know the exact fee, what is included in the fee, and what payment options, including *financing*, are available. Some procedures may be eligible for insurance benefits.

---

6. How long is recovery? Most cosmetic facial surgery is now done in office facilities—on a "same day" basis. Hospitalization is usually not necessary. A "hideaway retreat" should be available if you want to recover away from home. Returning to work and normal activities is often surprisingly prompt. For example, after nasal surgery, most people return to work in one week.

Your next step is to order this complimentary videotape.

About Face is now available to you. This fifteen minute video features personal interviews with seven patients. These men and women discuss their entire experience. They share with you their feelings about results, costs, recovery, and most importantly—how they feel about themselves. You will see their befores and afters showing nasal surgery, face and neck lifting, non-surgical wrinkle removal, and neck and chin sculpturing. With your video, you'll also receive *The Consumer's Guidebook to Cosmetic Facial Surgery*; it includes a 19 point checklist you can use during your consultation.

Here are some of the people you will meet in *About Face*

Carolyn Neff, 55—"I'm a registered nurse and have been for 10 years. I've worked with lots of cosmetic surgeons. . . I feel so good about having done it myself."

Brian King, 27—"When I was young, I was always being made fun of and kidded about my nose . . . And now I can honestly say I feel better and I look better."

Joan Richards, 49—"I had terrible wrinkles. There's a 100% difference now in how I feel. I go out and I look good, and that makes me feel good, too."

To receive your Video and Guidebook, call

213-553-5792

between 9 a.m. and 5 p.m.

Or mail this order form today

Facial Specialists Medical Group
2080 Century Park East, Suite 1408
Los Angeles, CA 90067-2058

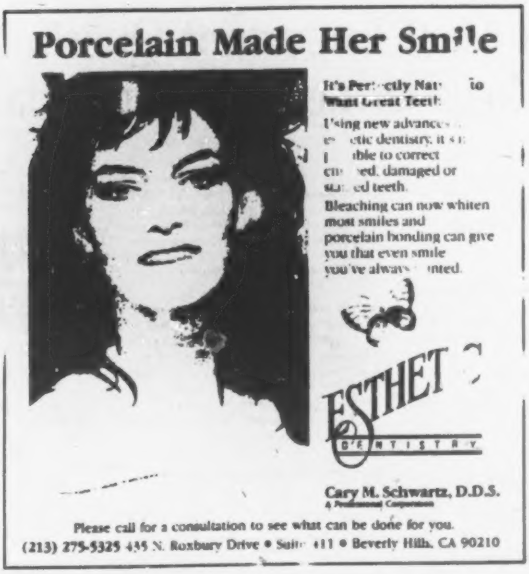
I'd like to see and hear how other people made their decisions about cosmetic facial surgery. Please send me a copy of the video *About Face* and *The Consumer's Guidebook*.

Name ________________

Address ________________

City ________ State ______ Zip ______

Phone ________________



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It's Perfectly Natural to Want Great Teeth.

Using new advances in esthetic dentistry, it's now possible to correct chipped, damaged or stained teeth.

Bleaching can now whiten most smiles and porcelain bonding can give you that even smile you've always wanted.

Cary M. Schwartz, D.D.S.
A Professional Corporation

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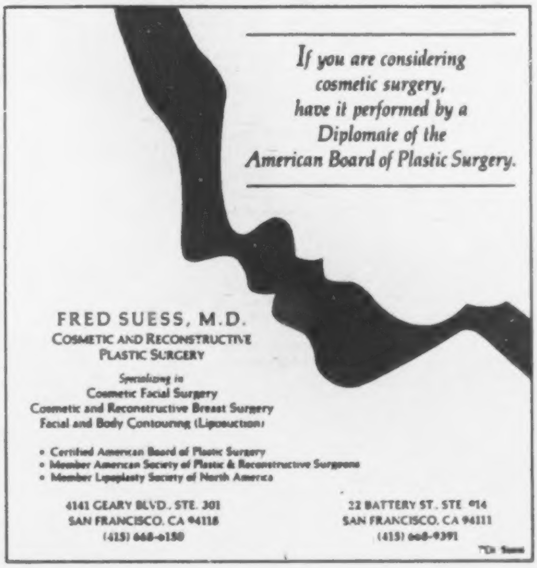
(213) 275-5325 435 N. Roxbury Drive • Suite 411 • Beverly Hills, CA 90210



If you are considering cosmetic surgery, have it performed by a Diplomate of the American Board of Plastic Surgery.

FRED SUESS, M.D.
COSMETIC AND RECONSTRUCTIVE
PLASTIC SURGERY

Specializing in
Cosmetic Facial Surgery
Cosmetic and Reconstructive Breast Surgery
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The secret for eyes that always look great? Ask one of the many women from around the country who have come to our respected specialists for the subtle beauty touch of permanent eye definition. Convenience you can't imagine – and a secret of perfection no one will ever guess. Call today for your free brochure.

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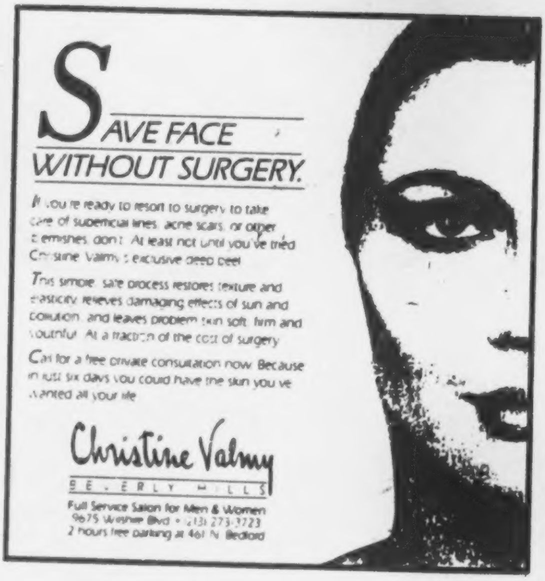

SAVE FACE WITHOUT SURGERY.

If you're ready to resort to surgery to take care of superficial lines, acne scars, or other blemishes, don't. At least not until you've tried Christine Valmy's exclusive deep peel.

This simple, safe process restores texture and elasticity, relieves damaging effects of sun and pollution, and leaves problem skin soft, firm and youthful. At a fraction of the cost of surgery.

Call for a free private consultation now. Because in just six days you could have the skin you've wanted all your life.

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by surgical removal of fat

Liposuction is a special surgical procedure *for men and women* used to remove unwanted fat from areas of the body that dieting—and even exercise—does not touch.

Nose, chin and cheek surgery, breast enlargement and reductions, as well as, eye and face lifts are other surgical procedures that can enhance the way you look and feel about yourself.

To arrange a free confidential consultation with Dr. Anderson, call:

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1-800-THE-NEW-U.
(1-800-843-6398)

Roger W. Anderson, M.D.
COSMETIC SURGERY ASSOCIATES
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Suite 616
Rockville, MD 20852

2406 I Street, N.W.
Washington, DC 20037

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NOSES

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by surgical removal of fat

Liposuction is a special surgical-procedure *for men and women* used to remove unwanted fat from areas of the body that dieting-and even exercise-does not touch.

Nose, chin and cheek surgery, breast enlargement, as well as, eye and face lifts are other surgical procedures that can enhance the way you look and feel about yourself.

To arrange a free confidential consultation call:

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1-800-THE-NEW-U.
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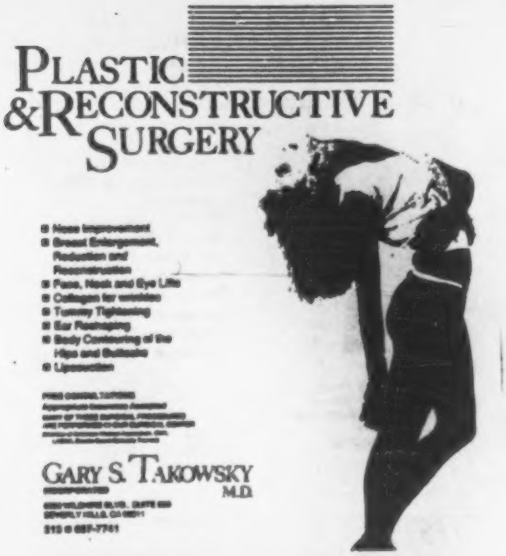

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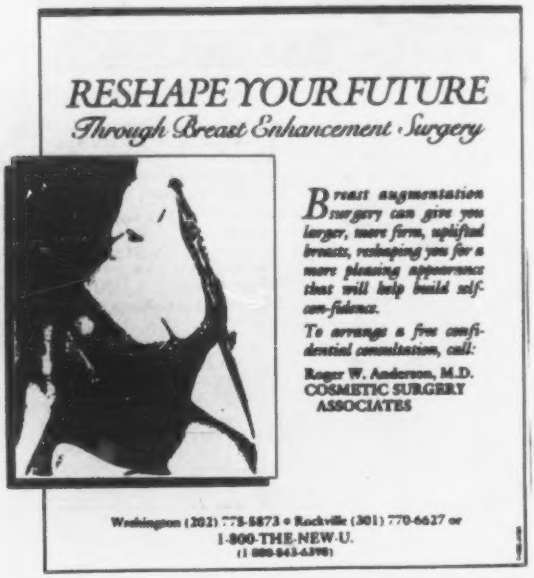

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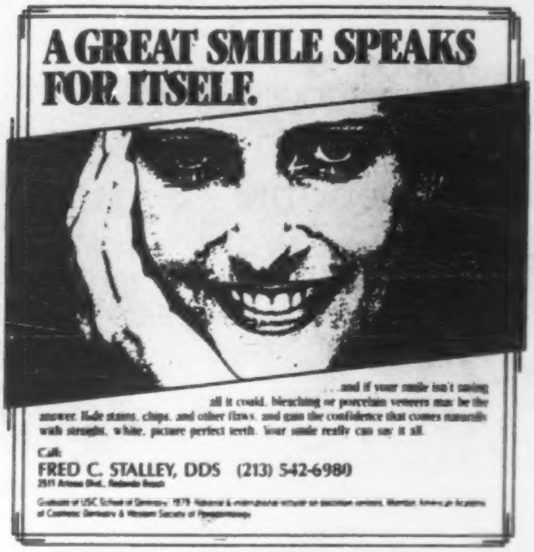

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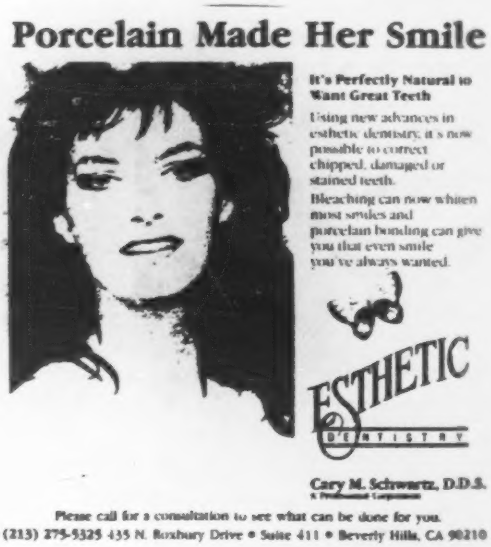

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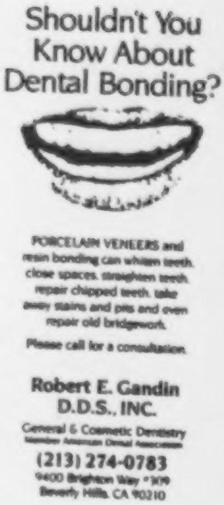

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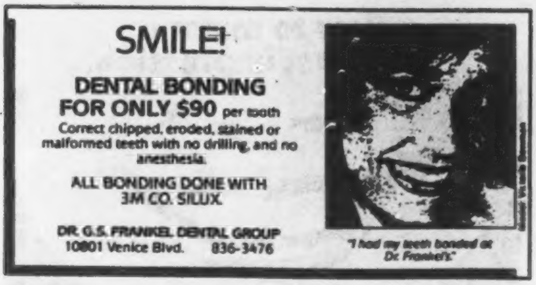

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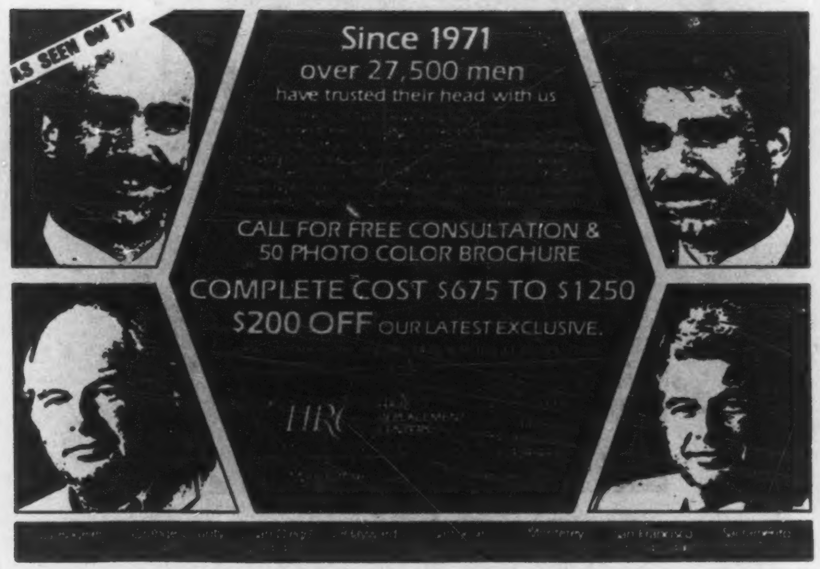

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STATEMENT OF ANGELA R. BROWN

BEFORE THE
SUBCOMMITTEE ON REGULATION, BUSINESS OPPORTUNITIES & ENERGY

APRIL 4, 1989

My name is Angela R. Brown. I am executive director of Richard's House, a home for throw-away children. Before I tell you what happened to me, I want to express my gratitude that you are trying to educate the public about the seriousness of liposuction.

I chose to have liposurgery only after years of exercise and dieting that did not remove the saddlebags -- that excess fat on the sides of my thighs.

I was led to believe that liposurgery was simple and successful. And since I felt that I had chosen a qualified board-certified plastic and reconstructive surgeon, I was sure everything would be just fine.

When I had a preliminary conference with the doctor, he told me, "You have good skin tone. You're not overweight, and the results will be great." I underwent surgery on May 13, 1987.

Little did I know that after the surgery I would never be the same: not just in my outward appearance, but in my mental and emotional state, as well. I was in surgery for over two hours, as opposed to the initial 45 minutes the doctor said it would take to remove my saddlebags. This was due to the lipo machine which kept breaking down.

After the operation, I felt fine. I asked the nurse how much fat was removed. She replied, "lots more than I thought you had." She showed me a jar filled with my yellow fat. It looked like chicken grease.

Shortly afterwards, I went home and felt fine. About three or four weeks after the surgery I noticed my right leg was caving in and was sensitive to the touch. So, I called the doctor and went for a check-up. As soon as he saw it, he calmly said, "I took out too much fat."

"Can it be corrected?" I asked.

"Yes, if it does not fill in, we can do fat grafts. That is when we remove fat from other areas of your body and use it to fill in and plump up the leg, but don't worry. You won't need it. Just rub your leg. Get your husband to massage it. Just think of all those good rub downs," he said with a snide grin.

However, my leg got worse. An area six inches long and six inches wide ran down the front of my right thigh. I could place my whole hand in the area. I could feel the muscle and the bone in my leg. The area was rock hard and it hurt.

Also, the skin tone was different. After a warm bath or shower the area would turn dark purple. My knee became three times its normal size. I could not bend my leg, nor put any pressure on it. I again returned to the doctor. Once more he told me, "Don't worry. Scar tissue is making the leg hard. Gradually the knee will return to normal. It's swollen due to the pressure of the scar tissue in your leg."

I kept returning to the doctor for months. Every visit with him was exactly like the previous one. I finally had to admit that my leg would not correct itself. Therefore, I visited several doctors to get their opinions.

One prominent board-certified surgeon -- another plastic surgeon -- told me too much fat had been removed, and I'd need two or three operations. Even then he said he was not sure if it would be all right. Then, he launched into the dangers of liposurgery: infection, hemorraging, or even death. He wanted me to sign a prepared paper stating everything that could go wrong, so if it did, he could not be sued for malpractice. I refused and visited another doctor.

As I entered this board-certified doctor's office, I saw a big sign: "Treat yourself to aa tummy tuck on your VISA Card and a buttock lift on your MASTERCARD." I was shocked. I had never heard of this before.

This doctor told me the same story. I had a 50-50 chance of having it corrected in three operations, costing $25,000. He was supposed to be the best doctor, but after I overheard him quote a $6,500 fee for surgery to one woman and then cut it in half to $3,500 because she had a prior surgery with him, I felt irate. He was charging me an exorbitant fee -- out of line with the cut-rate fee he was charging her.

So, I paid the fee for his consultation and left -- still an unhappy woman.

Then while watching television, I saw an advertisement for the Cosmetic Surgery Center. I figured, I've been damaged by one board-certified surgeon and visited two other board-certified physicians, who appeared to be money-grubbing specialists, so I had nothing to lose by seeing what this other option could be.

At the Center, I was introduced to Dr. Antonio Mangabat. He told me he had performed over 1,200 liposurgeries. Even though he was not board-certified, I trusted his record. He explained his procedure to me. Because liposurgery is an art dependent on experience as well as knowledge, his success record meant a great deal to me.

The difference between the initial board-certified doctor who ruined my leg and Dr. Mangabut who corrected it was astronomical. Dr. Mangabut gave me hope. He ws truly concerned and genuinely wanted to help me -- not just for the money.

Dr. Mangabut took a long time talking with me. He measured my leg and the other parts of my body from which he would remove fat. He and his nurse took numerous pictures of me. Then Dr. Mangabut wrote the prescriptions in advance for the antibiotics and pain pills I would need after the operation when I went home.

Even though I was quite nervous, Dr. Mangabut and his staff made me feel comfortable. Before the surgery, Dr. Mangabut took more photographs. Then, he marked up the parts of my body from where the fat would be removed with a green magic marker. He practiced careful medicine, taking blood tests and being scrupulously careful about sterile instruments and the dangers of infection. These were things the original doctor did not do.

After the sedation took effect, the doctor used his liposuction machine to remove fat from my left leg (which I had not realized was three inches larger than my right leg in the upper back of the thighs). This evened out the dents that were there. More fat was removed from my stomach and upper arms. This filled in the cavity.

I knew I had to wait three weeks to see if the fat cells would take. Since 50 percent of the fat cells are supposed to die, I hoped that the doctor had inserted sufficient fat.

After the operation my right leg was severely swollen and hurt with a throbbing intensity.

I realized then that undergoing surgery to become slim and trim was not an issue to be considered trivially. Liposurgery is surgery. Things can and do go wrong.

Many people have admitted to me that they too have had problems. Yet, they felt ashamed to admit that the elective operation did not come out correctly. Many of the men and women who have undergone liposurgery need corrective operations but are either afraid or too ashamed to have them. They suffer silently.

I will not be silent about the dangers of liposurgery. I am very pleased that this Committee has chosen to expose the problem and help the thousands of people who are unaware of the problems inherent in liposurgery, or of the unscrupulous and unskilled doctors who may be board-certified surgeons but still be butchers and calculating money makers.

Yes, I am okay now -- except for a small fat pocket on my leg, and eventually I'll have this removed. But I would warn people to carefully consider whether the extra perfection is worth the risk.

STATEMENT OF JOYCE PALSO

BEFORE THE
SUBCOMMITTEE ON REGULATION, BUSINESS OPPORTUNITIES & ENERGY

APRIL 4, 1989

Congressman Wyden, thank you for allowing me to be here today to tell my story. Never in my life have I ever thought that I would be appearing before Congress. But there was a time that I thought I'd never have cosmetic surgery either.

Five years ago, I was a very happy, very healthy middle aged woman who owned a prosperous business that was growing by leaps and bounds. I began to notice so many advertisements about cosmetic surgery - it all sounded so simple. I decided I could stand a tuck here and there to improve my looks and perhaps look younger. The ads almost sounded like going to get a tooth filled - go in in the morning, have a tummy tuck done, a face lift, or a breast enlargement and go home in the afternoon. No need to go to a hospital - doctors were doing these procedures in their offices.

I thought this must be safe or who in the medical profession or government would allow doctors to do this. I thought things like that were controlled by the A.M.A., the states or at least someone. So I went for consultations with five plastic surgeons. Several could not schedule me in when I needed because of my work schedule. I found one close to my home who could fit me in. I talked about a tummy tuck, a breast lift and a face lift at the same time.

I asked for a list of his credentials and for names of patients whom he had done these procedures on. His list of credentials looked quite impressive. I know now that most of the things he had listed meant absolutely nothing other than the fact that he did have an M.D. degree. I called A.M.A. in Chicago to check on him. I was told that he "was a member in good standing." I now know what that meant was only that he had paid his dues. I called the California Board of Medical Quality Assurance in Sacramento and asked about this doctor. They told me "they had nothing on him." I thought that meant they had nothing negative on him. He also had listed University of California, Davis. I called them and was told that he may have attended a seminar there regarding plastic surgery. The person on the line then told me to be sure I chose a Board Certified Surgeon. I looked on the doctor's credentials and noticed that he had listed that he was a member of the Board of Cosmetic Surgeons.

I did not know the difference then, but I certainly do now! From what I had been told and from his very impressive credentials that he had given me, I then asked to talk with some of his patients. I did meet with and talk with three of them. I believe, but I cannot be sure, that two of the three were decoys.

I then decided to make an appointment for the tummy tuck surgery. I was told by his office manager to bring cash or cashier's check to the office. I don't know why I did not think that strange at the time.

I went into his office very early on the morning of August 27, 1984. He performed a tummy tuck on me. That surgery requires a 12" incision from hip bone to hip bone. I went home at 4:00 that afternoon. Then I went back to his office the next Wednesday for him to remove drains. Then I went again on Friday. He told me not to change the bandage or look at the incision. I should have thought that was strange also, but I didn't question it at the time. The next Monday was a holiday so I did not go back until the next Wednesday - five days after the last vivsit when he told me not to change the bandage.

On the 9th day, he began to remove the sutures and said that something was not right, but, "not to worry, everything would be okay." I had been coughing and complained of the coughing. He said it was just the after effects of surgery.

On the 10th day after surgery, I noticed seeping coming through the bandage. I took the bandage off and saw something very freightening. It looked like two coal black places, each the size of a table spoon and another red, bloody, pussy place the same size. I called his office and was told that he was not in, to put another bandage on and come in the next day.

Shortly after that, he told me there was some infection, but that it would be okay. The wound then began to have a terrible odor, I was still coughing and had become short of breath all of the time. Each time that I would go in, I would tell him the same complaints - he kept saying it was the after effects of surgery. He changed antibiotics three times.

Finally, at my suggestion, he took a culture and I heard him talk to the lab about the report. Apparently, they told him that those particular infections (there were three different kinds; never respond to oral antibiotics. He said he did not want to give injectibles. When I asked him why, he said that it would be expensive for me. I remember saying that I did not care - I just wanted to get well.

By this time, I was getting very weak and was very short of breath. Against his advice, I went for another opinion the very next day after I last saw him. When I called and told another doctor what was happening, he told me to get a chest x-ray before I even came to his office. The doctor that performed the tummy tuck - even with all my complaints - had never taken my blood pressure, a blood test, listened to my heart or suggested a chest x-ray.

By the time I reached the other doctor's office, he had the x-ray, looked at the open, gaping wound, and called a pulmonary specialist. He told my daughter, who had taken me in to the office, to get me to the ~~emergency at~~ the hospital immediately. The pulmonary specialist was there when I got there. They thought I had blood clots in my lungs. After many tests, lung scans, etc., the pulmonary specialist extracted a cup of fluid from my left lung. Also in the emergency room, they started cleaning out the wound. I looked and saw what looked like a crater full of blood and greenish looking pudding. There were in a very short time, five different specialists on my case. The pulmonary specialist discovered that there was something wrong with my heart and called in a cardiologist.

After the tests, it was discovered that the infection from the wound had gotten into my blood stream and had landed on the mitral valve in my heart. An infectious disease specialist was called in, an internist, and another "real" plastic surgeon. After being in the emergency room for seven hours, I was admitted as an inpatient.

The cardiologist came into my room the next day and explained to me what had happened. He told me that I had saved my own life by getting a second opinion when I did. If I had waited much longer, I would not be here today to tell this story.

He told me that the mitral valve was so damaged by the infections that I would have to undergo open heart surgery, but that they could not operate until the infection was under control The infections were staph, pseudemonous and one other one which they began to treat with intravenous antibiotics - two different ones. The wound was cleaned every three hours. I was in the hospital for two weeks, had home health care for four weeks, was taught to infuse my own antibiotics through a heparin lock, and had to go back to the hospital for six weeks for hydrotherapy and cleaning of the wound.

In one year I was in and out of the hospital six times. I also went into heart failure five times. The infections would not go away, so my doctors decided to open me up to see if they could find out the reason. But because of my heart, they could not give me general anesthetic, so I was awake under local anesthetic when they opened me up. They found a foot of suture that the doctor had left inside me and the infection was clinging to that suture.

After that, the infections would go away , then they would pop up again. We had the heart surgery scheduled for August, 1985, but then the infections appeared again so it had tc be postponed.

Six days before Christmas in 1985, I had a stroke. The defective valve threw a clot which landed in the right side of my brain, affecting my left side. I could not talk and I could not swallow. Heart surgery was scheduled for February 11, 1986.

When I was roled into surgery, I did not know if I would ever see my children again. Thanks to all my doctors who saved my life, I am now, four and a half years later, living a normal life. I must listen to the tick of my artificial mechanical valve in my heart. I hear it tick with every heart beat. I am on blood thinner for the rest of my life, so I must be very careful not to cut myself or I could lose a dangerous amount of blood. I must live with the horrible scars on my abdomen because my doctors will not allow me to have reconstructive surgery. I must go to the doctor once a month for life.

Needless to say, I lost all my business when this happened to me. Today, I am in the process of trying to rebuild that business. I lost a large amount of money which I will never be able to recoup. But I want to tell you this: IT IS GREAT TO BE ALIVE. The doctor who did the tummy tuck on me did the same procedure on a 36-year old registered nurse two months after he did me. She died from the same complications and infections that I had. SO I AM THE LUCKY ONE.

The reason that I am here today is to try to convince someone to get control of the unqualified doctors out there who are advertising and cutting on people. It is my understanding that no one has any control - as long as a person has an M.D. degree he can advertise and do anything he wants to do, anywhere he wants to do it. When the California State Investigator came to see me, she told me that they had been trying to get the doctor's license away for two years before I went to him, and that he had eleven lawsuits against him when I went to him. I asked why, when I called Sacramento, they had not told me that. She said that he had not been proven guilty on any of the cases so they couldn't tell me. It takes sometimes four and one half years to get a trial date for medical malpractice in California, so does that mean in the meantime that these guys can keep cutting on people? In my case, it did. If I had been told when I called Sacramento, I would not have had to go through what I did.

It took my case and the woman who died to get his license revoked - four years after the state began to try to get it revoked. There were many people injured by this doctor in four years time!

The A.M.A. has no control. DO THEY CARE? The State Medical Quality Assurance Boards have their hands tied by the judicial system and a backlog of so many cases and a shortage of staff. The federal government apparently has no control. DOES ANYONE CARE? I CARE and I don't want anyone else to have to go through what I went through. PLEASE - SOMEONE MUST TAKE CONTROL OF THESE UNQUALIFIED PHYSICIANS who are calling themselves all sorts of "Cosmetic Specialists."

Some of these doctors are very clever and can form whatever board they want to, get a group together, pay some kind of dues, go to a local printer and have impressive certificates made up to hang on their walls. DOES THAT QUALIFY THESE DOCTORS TO DO WHAT THEY ARE DOING? Does attending a seminar or course qualify these doctors to do what they are doing? I AM LIVING PROOF THAT IT DOES NOT!

The medical profession is a powerful one. Today, I know the difference between the Board of Platic and Reconstructive Surgery and the Board of Cosmetic Surgeons. I did not know the difference when I chose the doctor that I did. If there is a group of doctors that chooses to form a so-called "board", shouldn't they be responsible to make sure that their members are really qualified.

Shouldn't the government, at the very least, stop doctors' ads that lull us into a false sense of security. Shouldn't ads that make us believe that we can have cosmetic surgery done safely and well with no risk be stopped? Whose job is it? Should the Federal Trade Commission be responsible? Should the Food and Drug Administration be responsible?

All I know is that someone in government should be doing that job.

QUALITY ASSURANCE IN PLASTIC SURGERY

Presented by
John R. Jarrett, MD
President-Elect
American Society of Plastic and Reconstructive Surgeons

April 4, 1989

Subcommittee on Regulation, Business Opportunities and Energy
Committee on Small Business
U.S. House of Representatives

Since 1931, the mission of the American Society of Plastic and Reconstructive Surgeons has been to "promote optimal care for plastic surgery patients through education, research and the maintenance of high professional standards. . ." These are lofty ideals that other physicians and organizations may also espouse; however, unlike many mission statements, ours is more than a paper exercise. To the fullest extent possible, we police who joins and remains in our Society to assure that for patients, membership is synonymous with quality.

To be accepted as an active member of ASPRS, candidates must first earn certification from the American Board of Plastic Surgery, the only board authorized to certify plastic surgeons by the American Board of Medical Specialties. In his presentation, Dr. Noone outlined in some detail the extensive training and testing requirements that physicians must satisfy to achieve this status.

In addition, every applicant must be sponsored by two active members who are familiar with the individual's professional competence and code of ethics. The Society's Membership Committee then thoroughly evaluates the candidate's background and reputation. Only then is the application put to a vote at the annual ASPRS Business Meeting, where he or she must be approved by at least four-fifths of those in attendance.

However, ASPRS considers membership to be a right that must be continually earned. As outlined in Dr. Noone's presentation, each ASPRS member must successfully complete at least 150 hours of continuing medical education every three years. ASPRS and its Plastic Surgery Educational Foundation (PSEF) sponsor an annual, five-day scientific conference, as well as an average of 20 topic-specific seminars every year. Videoteleconferences, sponsored four times a year, beam live surgical demonstrations by the country's top experts into viewing sites across the nation. In addition, the Society's monthly journal of Plastic and Reconstructive Surgery is considered the leading scientific publication for the specialty and commands a circulation of 12,947. Finally, the PSEF's Self-Assessment Exam, which is offered each year to medical residents as well as practicing plastic surgeons, tests our members' assimilation of the ever-expanding body of knowledge about reconstructive and cosmetic surgery.

To plan this comprehensive curriculum, which has been approved by the Accreditation Council for Continuing Medical Education, ASPRS has seven committees of volunteer physicians and PSEF has 24. In addition, in response to concerns expressed by the government and third-party payers, ASPRS established five committees to define minimum treatment requirements for plastic surgical care. The committees have nearly finished developing standards for the first five targeted procedural areas: Dupuytren's contracture, lipodystrophy, micromastia, nasal deformity and facial rejuvenation. Their work will not be done until they have defined similar standards for each and every procedure performed by plastic surgeons.

Proper training, certification and continuing education go a long way towards assuring a plastic surgeon's competence. However, a final, more intangible element is the surgeon's ethical and moral code. To remain a member of ASPRS, physiciains must strictly adhere to the Society's Code of Ethics. Disciplinary action ranging from private censure to expulsion may be imposed on members who exhibit professional incompetence; are convicted of a felony or other crime related to moral turpitude or their practice of medicine; charge exorbitant fees or are involved in other improper financial dealings; use any form of false, fraudulent or deceptive advertising; or perform an unjustified surgical procedure.

As described in the ASPRS Bylaws, any person (from inside or outside the organization) may report a member's suspected violation of the Society's Code to the Ethics Committee. This committee evaluates the complaint and if warranted, forwards it to the ASPRS Judicial Council, which holds a hearing and takes disciplinary action. Since the fall of 1980, when the Code of Ethics was adopted, 170 formal investigations have been conducted. As a result of hearings before the Judicial Council, four members have been expelled, four have had their membership suspended, four have been placed on probation, one has been publicly censured and seven have been privately censured.

In addition, ASPRS authorizes the work of a Surgical Greivance Committee, which is a forum for patients who are dissatisfied with the care they have received from Society members. The committee evaluates each complaint, collects additional information when needed (including arrangement for a second opinion) and attempts to resolve any conflict that exists by acting as an impartial arbitrator.

I have described these internal activities to illustrate the Society's commitment to high professional standards -- even when it means taking action against our own members. However, we can only do so much; the state and federal governments must do their part as well to assure patient welfare.

ASPRS believes that the existing board certification process, if allowed to function as it was originally established, can be extremely effective in protecting the public from unnecessary risk of injury. However, if individuals are allowed to create boards without the review and approval of the American Board of Medical Specialties, and if physicians are permitted to advertise board certification without saying which board has tested them, then the entire quality assurance process loses its meaning. The ABMS has stated unequivocably that only diplomates of the American Board of Plastic Surgery are considered certified in the specialty. In addition, both the American Board of Otolaryngology and the American Academy of Facial Plastic and Reconstructive Surgery have issued formal policies against members who perform cosmetic plastic surgery beyond the head and neck. However, physicians whose formal training is limited to otolaryngology -- or dermatology, gynecology, family practice, etc. -- are advertising their willingness to perform breast augmentation and body sculpturing -- often attached to a claim of board certification and the self-designated title of "cosmetic surgeon."

According to its membership brochure, the American Academy of Cosmetic Surgery will accept dentists, dermatologists, gynecologists and other types of physicians based only on a submitted list of 100 plastic surgery procedures performed during the previous year. This is hardly a measure of quality and any advertisement that holds out membership in the American Academy of Cosmetic Surgery as a professional qualification to practice the specialty is misleading. Many AACS members point to their certification by the "American Board of Cosmetic Surgery" as added proof of their qualifications. But how can a consumer possibly be expected to know that the American Board of Cosmetic Surgery is a separate entity from the the American Board of Plastic Surgery; that it is not recognized by an independent review body, namely the American Board of Medical Specialties; and that it does not require any formal residency training relating to cosmetic surgery? It is our firm belief that the Cosmetic Board was created merely to provide a vehicle to induce the public into thinking that its members have more training in the specialty than they actually have. Yet the very fact that it has been allowed to exist has given it and its members instant credibility.

An example of the questionable activities undertaken by these cosmetic surgery organizations is a weekend seminar sponsored by the American Academy of Cosmetic Surgery to teach physicians from any and all disciplines how to perform breast surgery, abdominoplasty ("tummy tuck"), suction-assisted lipectomy and fat transplants. The course featured instruction in the use of fat injections for breast augmentation. This is a practice that has been widely condemned by surgeons properly trained in such surgery, based on evidence that fat injections produce calcifications that mimic or mask the presence of cancer when viewed on a mammogram. I have submitted copies of the flyer promoting the AACS program, as well as of two letters published in the Journal of Plastic and Reconstructive Surgery describing the dangerous nature of fat injection in the breast. It is not surprising that the person promoting and teaching this process is an otolaryngologist by original training. In my opinion, the only benefit from this procedure is to the bank accounts of unscrupulous physicians.

It is painfully obvious that the consumer faces significant obstacles when trying to find a qualified plastic surgeon. This is due in large part to the removal of restrictions on medical advertising, initiated by the FTC in 1975. Not only are the resulting advertisements by untrained physicians endangering public safety, they are also eroding public trust of and respect for the medical community. Visiting a surgeon who is certified by an ABMS-recognized board and is working within the scope of his or her training is not an absolute guarantee of good results, but we believe it is the most reliable bottom line.

The law of the land should allow only ABMS-recognized boards to exist, and should require physician advertisers to name the specific board when claiming to be "board-certified." In addition, action is needed to limit physicians' licenses to the services in which they are formally trained, and to extend peer review programs to surgery performed in physicians' offices. Otherwise, consumers are left to fend for themselves, without even the benefit of the information they need to make an informed choice.

John R. Jarrett, M.D.

TESTIMONY TO CONGRESSMAN'S WYDEN'S COMMITTEE

In my prepared text which I have submitted, I have described the organization of the American Society of Plastic and Reconstructive Surgeons in some detail -- including our mission statement, our membership requirements, the ongoing educational activities we provide for our members and our very strict code of ethics. In that document, I have stated that we endeavor to police ourselves by insisting on strict enforcement of our code of ethics -- violation of which may result in censorship or expulsion. Since this code of ethics was enacted in 1980, we have publicly censored eight members, placed four on probation, suspended four for various lengths of time and expelled four members. The majority of these sanctions have been for violation of our very strict code regarding advertising policies. We continue to enforce this code of ethics for we are convinced that it is in the patient's best interest to do so.

My colleagues and I have described our training, education, certifying, moral and ethical requirements in detail because I believe they present the ultimate in preparation for treating patients in a wide spectrum of plastic surgical services, including cosmetic surgery.

You may hear in later testimony from physicians certified by the American Board of Cosmetic Surgery reasons why they think their training qualifies them for the performance of cosmetic surgery. Mr. Chairman, the bottom line is that there is no, and

I mean no, substitute for accredited residency training and certification by a board that is recognized by the American Board of Medical Specialties. During the testimony that will be given by members of the American Academy of Cosmetic Surgery who are certified by the American Board of Cosmetic Surgery, remember that organized medicine, the American Medical Association, the Counsel of Medical Specialties do not recognize weekend courses or month-long fellowships as any official measure of credibility and certainly not as a substitute for formal residency training. Among the requirements published for certification by the American Board of Cosmetic Surgery are a history of having performed 1,000 cosmetic cases plus being certified by another recognized board. But that other board could be the American Board of Obstetrics, Family Practice, Dermatology, or even Urology, all programs that provide no training in cosmetic surgery. Therefore, even though they may have performed 1,000 cases, those cases have been performed without the benefit of any formal residency training and therefore is no assurance that they have been properly performed. Furthermore, the first step into membership or certification by the American Board of Cosmetic Surgery is membership in the American Academy of Cosmetic Surgery that requires cnly the performance of 100 cosmetic cases and additionally requires no type of post-graduate training of any kind. In other words, any medical school graduate after he has done 100 cosmetic cases, and I believe that even simple skin lesion excision or laceration repair can be called a cosmetic case, is allowed to display a diploma from the American Academy of Cosmetic Surgery, deceiving the unsuspecting public into thinking that physician is a trained cosmetic surgeon. Using this deception, this physician does 1,000 more cases and is then allowed to be certified by the American Board of Cosmetic Surgery. Mr. Chairman, I fear for the safety of the 1000 patients these physicians are operating upon as they earn their way into qualifying for certification by the American Board of Cosmetic Surgery.

This is exactly why ASPRS always has, and will continue, to use every possible media source to inform patients that they should be treated by surgeons who are certified by an ABMS recognized board and who also are operating within the scope of their residency training and certification. You will also hear much testimony today from others, criticizing ASPRS for trying to protect our "turf" by so informing the public. Gentlemen, I believe that we have been doing exactly what you would want to do yourself to help assure public safety. When organized medicine has a well established process of recognizing, evaluating, and controlling residency programs and board certification, what possible reasons are there for physicians trying to circumvent the standards? You all have seen the video tape where Dr. Aronson stated why he formed the American Board of Cosmetic Surgery several years ago "so that he could tell patients that he was board certified in cosmetic surgery." This is a blatant admission of deception, intended only to provide false credentials in order to attract patients and ultimately to enhance the pocketbooks and bank accounts of these physicians.

ABMS recognized Boards were formed solely to establish a high standard of care and to help protect the public.

Dr. Cole has previously described the process of hospital credentialling for the performance of surgical procedures in hospitals. You will probably hear testimony from others today that plastic surgeons have been responsible for influencing hospital credential committees to deny surgical privileges to physicians certified by the American Board of Cosmetic Surgery. As Dr. Cole has testified, hospital credential committees are the ultimate in peer review and are made up of representatives from all fields of medicine. These are intelligent physicians who can easily see through the deception of certification by the American Board of Cosmetic Surgery without any input from properly trained plastic surgeons. Representatives of the American Board of Cosmetic Surgery may in fact state that their failure to get hospital privileges has driven their members to office based surgery and may further state that the ASPRS should again be reported to the FTC for trying to limit office surgery by supporting legislative efforts to extend hospital credentialling to office surgery. It is precisely because these "cosmetic surgeons" are legally able to perform cosmetic surgery in their offices for which they do not have hospital privileges that ASPRS does support extending the peer review process to office surgical facilities. How can any honest physician feel that his office practice should not be subject to the same peer review procedures as his hospital practice is? The only ones who fear that type of peer review are those who lack the formal training to receive full accreditation for hospital surgery.

The bottom line of this issue regarding unqualified surgeons is that they have seen cosmetic surgery as a lucrative practice and are trying to jump on the band wagon without the formal training required by organized medicine. Our bottom line is quality care for our patients.

In view of an obvious absence of approved training in cosmetic surgery as a requirement for membership in The American Academy of Cosmetic Surgery and board certification by the American Board of Cosmetic Surgery and groups such as the American Academy of Cosmetic Surgery, the artificial credentials produced by membership in these organizations presents a severe danger to public safety. While physicians working within the scope of their ABMS board certification and training does not guarantee perfection, it is at least a measure of the best possible preparation. Poor results, even disasters, occasionally occur in all areas of medicine from treatments by properly trained physicians. This is all the more reason why we must continue to upgrade, scrutinize, and restrict privileges rather than open Pandora's Box to bestow dangerous and false credibility upon untrained physicians and thus allow them to deceive the public into thinking that these physicians are recognized by the certifying system of American Medicine as a fully trained specialist.

Mr. Chairman, in conclusion, as President-Elect of the American Society of Plastic and Reconstructive Surgery, I would like to submit five recommendations to your committee:

1. Only boards recognized by the American Board of Medical Specialties should be allowed to exist. Within the current 23 recognized boards this would include officially sanctioned cosmetic surgery training within the spectrum of the American Board of Plastic Surgery and also within the spectrum of the American Board of Otolaryngology which includes training in cosmetic procedures of the face.

2. All outpatient surgical facilities should be accredited by an official accrediting agency.

3. Physicians performing cosmetic procedures in their office facilities should be limited to only those procedures for which he or she has privileges in a fully accredited hospital.

4. All advertisements stating that a physician is board certified must name the certifying board and whether or not it is recognized by the ABMS or merely a self-designated specialty board.

5. Encourage the FTC to adopt strict advertising guidelines along the lines that several states have recently done, such as California which has specifically restricted what may and may not be advertised.

Mr. Chairman, we would be pleased to answer your questions.

AMERICAN SOCIETY OF
PLASTIC AND RECONSTRUCTIVE
SURGEONS, INC

FACT SHEET

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312-228-9900

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ESTIMATED NUMBER OF COSMETIC SURGERY PROCEDURES PERFORMED BY ASPRS MEMBERS

Procedure	1988	1981		Percent Increase
Breast augmentation	71,720	72,000		--
Breast lift (mastopexy)	12,440	12,800		--
Breast reduction	35,500	32,000		11%
Cheek augmentation (malar augmentation)	3,140	N/A		N/A
Chemical peel	9,430	9,700		--
Chin augmentation (mentoplasty)	12,730	N/A		N/A
Collagen injections*	68,880	N/A		N/A
Dermabrasion	20,250	17,000		19%
Ear pinning (otoplasty)	9,930	11,500		-14%
Eyelid surgery (blepharoplasty)	78,490	56,500		39%
Facelift (rhytidectomy)	48,480	39,000		24%
Fat injections*	9,680	N/A		N/A
Fibrel injections*	1,540	N/A		N/A
Forehead lift	14,800	N/A		N/A
Hair replacement	2,220	4,200		-47%
Liposuction	101,000**	55,900	(1984 figure**)	81%
Hips/thighs 34%				
Abdomen [illegible]				
Face [illegible]				
Buttocks [illegible]				
Legs 9%				
Nose reshaping (rhinoplasty)	73,250	54,500		34%
Retin-A*	59,360	N/A		N/A
"Tummy tuck" (abdominoplasty)	48,230	15,300		215%
ESTIMATED TOTALS	681,070	380,400		80%

SEE EXPLANATORY NOTES ON BACK

1988 TREATMENT LOCATIONS AND FEE RANGES FOR ASPRS COSMETIC PATIENTS

	AVERAGE FEES		TREATMENT LOCATION			
Procedure	High	Low	Office	Free-Standing	Hospital Outpatient	Hospital Inpatient
Breast augmentation	$2,370	$1,970	50%	19%	27%	4%
Breast lift (mastopexy)	2,830	2,240	42%	13%	27%	18%
Breast reduction	3,850	3,090	9%	47%	34%	10%
Cheek augmentation	1,680	1,400	64%	16%	13%	7%
Chemical peel	1,270	680	77%	9%	9%	5%
Chin augmentation (mentoplasty)	1,160	520	56%	15%	21%	8%
Collagen injections	240	170	99%	<1%	0%	0%
Dermabrasion	1,300	620	56%	11%	26%	7%
Ear pinning (otoplasty)	1,810	1,490	37%	15%	41%	7%
Eyelid surgery (blepharoplasty)	2,330	1,800	62%	11%	22%	5%
Facelift (rhytidectomy)	3,860	2,980	58%	11%	14%	17%
Fat injections	570	320	90%	3%	7%	0%
Forehead lift	1,920	1,430	61%	16%	16%	7%
Hair replacement	1,340	820	70%	7%	17%	6%
Liposuction	1,750	830	46%	15%	30%	9%
Nose reshaping (rhinoplasty)	2,580	1,710	35%	14%	33%	18%
Retin-A*	64	30	100%	0%	0%	0%
"Tummy tuck" (abdominoplasty)	3,390	2,540	33%	8%	24%	35%

NOTE: Fees listed represent average highs and lows for the entire country. Costs could vary significantly from these estimates depending on the geographic location, complexity of the particular operation, etc. Treatment locations represent those surgeries performed in the doctors' offices, free-standing surgi-centers and hospitals.

*Estimated fees for Retin-A are based on the per visit cost, excluding the expense for the medication itself.

1988 SEX AND AGE DEMOGRAPHICS FOR ASPRS COSMETIC SURGERY PATIENTS

			AGES			
Procedure	Male	Female	<18	19-34	35-50	50+
Breast augmentation	0%	100%	2%	65%	30%	3%
Breast lift (mastopexy)	0%	100%	1%	62%	31%	6%
Breast reduction	0%	100%	9%	47%	34%	10%
Cheek augmentation	24%	76%	3%	45%	42%	10%
Chemical peel	12%	88%	<1%	5%	44%	50%
Chin augmentation (mentoplasty)	24%	76%	9%	48%	32%	11%
Collagen injections	9%	91%	1%	19%	53%	27%
Dermabrasion	22%	78%	7%	48%	27%	18%
Ear pinning (otoplasty)	53%	47%	* (see note below)			
Eyelid surgery (blepharoplasty)	23%	77%	<1%	8%	49%	43%
Facelift (rhytidectomy)	12%	88%	0%	2%	37%	61%
Fat injections	22%	78%	1%	28%	46%	25%
Forehead lift	10%	90%	0%	4%	47%	49%
Hair replacement	100%	0%	8%	44%	43%	5%
Liposuction	13%	87%	2%	44%	39%	15%
Nose reshaping (rhinoplasty)	28%	72%	16%	54%	25%	4%
Retin-A	13%	87%	1%	16%	43%	40%
"Tummy tuck" (abdominoplasty)	23%	77%	15%	22%	39%	24%

* Otoplasty:		
	Newborn to 2 -- 1%	13-18 -- 16%
	3-6 -- 21%	19-34 -- 22%
	7-12 -- 31%	>34 -- 9%

NOTE: Overall, 16% of cosmetic plastic surgery patients in 1988 were males.

Top 4 cosmetic procedures for males in 1988-- rhinoplasty (20,720), blepharoplasty (17,950), liposuction (13,530) and abdominoplasty (11,090).

Top 4 cosmetic procedures for females in 1988-- liposuction (87,480), breast augmentation (71,720), collagen injections (62,540) and blepharoplasty (60,540).

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DID YOU KNOW. . .

...that when asked about their attitude towards cosmetic plastic surgery, a random sample of consumers (mostly women older than 25) said they:

	1980	1982	Percent change
Approve of cosmetic surgery for themselves and others	48%	32%	+50%
Approve of cosmetic surgery for others but not themselves	16%	19%	-16%
Were undecided	32%	39%	-18%
Disapprove of cosmetic surgery	3%	9%	-66%

...that when asked how long they had considered cosmetic surgery before taking action, these same consumers said:

Under one year -- 43%
1-2 years -- 25%
2-3 years -- 11%
3-5 years -- 7%
5-plus years -- 14%

...that a random survey of patients shows these demographics:

-- Slightly more than half (51%) are currently married

-- 83% have completed at least some college education, and 58% of those have some graduate education (persons with at least some college education are 13% more likely to choose cosmetic plastic surgery)

-- 30% have household incomes of $25,000 or less, 35% earn $25,000-$50,000, and 23% make $50,000 or over

[For information on how these studies were conducted, call the ASPRS Communications Department, 312-228-9900]

NOTES:

* The number quoted for injectables (including collagen, fat and Fibrel) represents the total patients treated, since more than one injection is often required to obtain the desired result.

- Likewise, the total quoted for Retin-A also reflects the number of patients, since more than one doctor's visit may be required for each individual.

** The number of liposuctions in 1988 and 1981 is estimated based on the number of different procedures performed, with each body site considered a separate operation. Therefore, if one patient had both the abdomen and thighs suctioned during the survey year, this is counted as two procedures.

Also, the number of liposuctions was quoted only for 1988 and 1984, since it was not introduced to the United States until 1982 -- a year after the first ASPRS survey..

THE EDUCATION AND CERTIFICATION
OF A PLASTIC SURGEON

Presented by

R. Barrett Noone, MD

President-Elect
Plastic Surgery Educational Foundation

Director
American Board of Plastic Surgery, Inc.

April 4, 1989

Subcommittee on Regulation, Business Opportunities and Energy
Committee on Small Business
U.S. House of Representatives

INTRODUCTION

In the United States, a medical "specialist" is defined as a licensed physician who has completed an accredited, graduate program of residency training in a specific area of medicine, leading to certification by a board approved by the American Board of Medical Specialties. Plastic surgery is such a specific area of medicine, and the residency training and certification of a true plastic surgeon fulfills the definition of "specialist."

A plastic surgeon treats contour problems and deformities in the integument (covering) of the human body, as well as its muscular and skeletal system. These deformities can be hereditary; caused by trauma or tumors; or the result of aging, childbearing and other conditions that inspire patients to seek improvement in their appearance. In all cases, reconstruction is performed with the goal of achieving the ultimate aesthetic as well as functional result for the patient. Operations for enhancing appearance are very closely related to procedures for restoring function; in most instances, one is not done without a concern for the other. When an elective cosmetic procedure is performed, it must be done within the functional parameters of the part of the body operated upon. In other words, a facelift operation cannot be done without taking into account the underlying muscles of the face and the nerves that control them. Likewise, suction lipectomy cannot be performed without regard for the loss of body fluids and metabolic changes that accompany the operation. Using this in-depth knowledge, the ultimate goal for cosmetic (aesthetic) surgery is improvement in appearance without compromise of function. Plastic surgeons consider patient safety as the foremost priority in achieving this goal, and by virtue of their intensive, lengthy, diversified training and experience, they are the specialists most uniquely qualified to perform elective aesthetic surgery.

This report details the graduate education, certification and continuing education required of plastic surgeons.

RESIDENCY TRAINING PROGRAMS

Residency training programs, which are open only to those who first obtain a general medical degree, involve substantial clinical work and prepare physicians for practice in one or more recognized medical or surgical specialty areas. Generally, physicians who complete this training become eligible to take the certifying examination for the corresponding specialty.

Accreditation

Accreditation of residency programs is conducted by the Accreditation Council for Graduate Medical Education (ACGME), a private, independent, national organization. The evaluation of post-graduate medical programs was initiated in 1914, when the Council on Medical Education and Hospitals of the American Medical Association first published a list of hospitals approved for internships. During subsequent decades, "Residency Review

Committees" were formed for each major medical specialty, including plastic surgery, to monitor the programs. In 1974, five medical organizations formed the Liaison Committee on Graduate Medical Education to coordinate the activities of the residency review committees. Nine years later, it was reorganized and renamed the Accreditation Council for Graduate Medical Education. Since that date, the Council has had the responsibility for accrediting all post-graduate medical education programs.

The five ACGME founders are the American Board of Medical Specialties, American Hospital Association, American Medical Association, Association of American Medical Colleges and Council of Medical Specialty Societies. Each of these organizations appoints four representatives to the 23-member Council. The remaining three seats are filled by a medical resident, a representative of the general public, and a liaison from the federal government (who is non-voting).

ACGME fulfills its mission by establishing standards for residency programs and procedures for their accreditation. Normally, the actual decision for or against a program's accreditation is made by the residency review committees, which are set up in each of 24 specialty areas and consist of volunteer physicians from those fields. However, when a decision is contested, ACGME serves as the "court of last resort."

ACGME accredits more than 6,400 residency programs in 24 major specialty areas and 45 subspecialties. These programs are sponsored by approximately 1,000 institutions across the nation -- primarily large, acute-care hospitals. Accredited programs enroll approximately 82,000 residents each year. Plastic surgery is one of the 24 major specialty areas with residency programs accredited by ACGME. There is no accredited residency program specifically for cosmetic surgery. This area of expertise is included in the residency program for plastic surgery.

Residency Requirements

The document called "The Essentials of Accredited Residencies in Graduate Medical Education" contains (1) General Requirements, which are standards applied to all residency training programs, and (2) Special Requirements, which pertain only to specific specialties. (Special requirements are now published for 69 different specialty or subspecialty areas.) General requirements are developed by ACGME and require approval by each of its five founding organizations. Special requirements are developed by each residency review committee, in consultation with appropriate experts, and are approved by ACGME.

Residency Review Committees

Each of the 24 residency review committees (RRCs) is sponsored by several organizations, usually including the American Medical Association and the appropriate certifying board. The Residency Review Committee for Plastic Surgery is sponsored by the American Board of Plastic Surgery, the American

Medical Association Council on Medical Education and the American College of Surgeons.

Members of the RRCs are appointed in equal numbers by each of the sponsoring organizations. Committee members -- who are all volunteers -- are active, practicing physicians. Their perspective places them in the best position to assure that ACGME's standards always reflect the state of the art in their particular specialties.

When a request for accreditation is received by ACGME, the training program is carefully examined in all respects, including facilities, resources, faculty and administration. The program or sponsoring institution is required to submit statistics and narrative information describing its course of training, and an on-site review is conducted. Based on the material prepared by the institution or program and the report of the on-site evaluator, the relevant residency review committee makes an accredition decision or recommendation. If an adverse decision is contested, reconsideration or appeal may be sought.

When a program becomes accredited, ACGME assumes responsibility for monitoring its continued adherence to high quality standards. Each program is reviewed approximately two years after its initial accreditation, and a minimum of every five years thereafter. Currently, programs are evaluated as often as every three and one-half years, in an attempt to conduct a review at least once during the training of every resident.

For patients, accredited residency programs mean around-the-clock staffing in hospitals by doctors from all major specialties, facilities equipped with advanced technology and physicians who are continually exposed to the latest medical knowledge. For physicians, accredited residency programs provide assurance of (1) training that meets nationally accepted quality standards; (2) recognition of their education by their professional peers; and (3) eligibility in most instances for state licensure and/or professional certification. For hospitals, state licensing bodies and certifying agencies, the completion of accredited residency programs is an indication of satisfactory professional training and competence.

The residency review committees that establish accreditation procedures, review programs and consider appeals are the ultimate in peer review among medical specialists.

MEDICAL SPECIALTY CERTIFICATION

Growth of Specialties

The growth of specialty medicine is directly linked to advancements in medical science and the resulting vast improvements in health-care delivery, evident since the turn of the century. During this period of growth, there was no system to assure the public that a physician claiming to be a specialist was indeed so qualified. Until the development of specialty boards, each physician had been the sole assessor of his or her qualifications to practice in a given field. Specialty societies and educational institutions encouraged the development of these boards, which were formed to define specialty qualifications, test eligible physicians and issue credentials. As these boards matured, it was only natural that they should coalesce and organize a national system for recognizing qualified physician specialists.

The concept of a specialty board was first proposed in 1908 by an ophthalmologist, Dr. Derek T. Vale. He stated: "I hope to see the time when ophthalmology will be taught in this country as it should be taught. That day will come when we, as occulists, demand (that) a certain amount of preliminary education and training be enforced before a man may be licensed to practice ophthalmology. It should no longer be possible for a man to be called an occulist, by himself or by the laity, after he has spent one month or six weeks in some post-graduate school or after serving as an assistant for six months or one year in some occulist's office. After a sufficiently long time of service in an ophthalmic institution in America or abroad, he should be permitted to appear before a proper examining board, similar to any state board of examination/registration, for examination, and if he is found competent let him then be permitted and licensed to practice ophthalmology."(2)

The problems currently being experienced in cosmetic surgery are setting the practice of this specialty back 80 years to the days of self-designation and limited training. This is appalling and certainly unnecessary when the pathways for training and certification have been well established in plastic surgery for the past 50 years.

The American Board of Medical Specialties

The primary function of the not-for-profit American Board of Medical Specialties (ABMS) is to promote quality and efficiency in the evaluation and certification of physician specialists. In addition, ABMS provides information to the public, the government and the medical profession. Likewise, the primary objective of each of its 23 member specialty boards is the improvement of the quality of medical education and health care. This mission is carried out by each of the specialty boards through their evaluation of candidates who wish to practice in a particular field. Those eligible physicians who voluntarily take and pass the appropriate examinations are certified as diplomates of their particular specialty board.

The responsibilities of the American Board of Medical Specialties include acting as spokesman for all approved specialty boards; ruling on proposals for new specialty boards, new types of certification and modification of existing certificates; avoiding duplication of effort by these boards; and establishing and maintaining minimum standards for member boards.

The ABMS has had the responsibility for approving medical specialty boards (through a joint action with the American Medical Association Council on Medical Education) since 1934. In May of 1938, the American Board of Plastic Surgery, Inc. -- the only board that examines its candidates in the complete spectrum of cosmetic surgery -- received recognition as a subsidiary of the American Board of Surgery. Exactly three years later, ABPS was awarded the status of a major, independent specialty board. Plastic surgeons certified by the American Board of Plastic Surgery are listed in the ABMS "Compendium of Certified Medical Specialists." Other boards recognized by ABMS may include in their examinations only those cosmetic procedures that involve the specific anatomic area related to their specialties. For example, the American Board of Otolaryngology may certify its candidates only in cosmetic surgery procedures on the head and neck. Likewise, the American Board of Ophthalmology may certify candidates only in cosmetic procedures that are limited to the eyelids. The American Board of Cosmetic Surgery is not, and never has been, recognized by the American Board of Medical Specialties. Like 104 other "self-designated" boards in the United States, it operates away from the watchful eye of any independent review body.

THE AMERICAN BOARD OF PLASTIC SURGERY, INC.

The primary purposes of the ABPS are to: (1) establish eligibility requirements for applicants wishing a certificate attesting to their qualifications in the entire scope of plastic surgery; (2) conduct examinations of approved candidates; and (3) issue certificates to those who meet the Board's requirements and pass its examinations.

Among the policies of the Board is a statement on advertising in medicine. According to the Board's booklet of information for 1988-89, it recognizes the role of legitimate advertising in the changing medical scene; however, it does not approve of advertising that arouses unrealistic expectations, is false or misleading, minimizes the magnitude and possible risks of surgery, or solicits patients for surgery that they might not otherwise consider. Such advertising is improper and inconsistent with the high standards of professional and ethical behavior implied by certification by the American Board of Plastic Surgery, Inc.

To be eligible to take the ABPS exams, candidates must meet the following training requirements:

Undergraduate Medical Degree

Candidates must have graduated from an accredited school of medicine in the United States or Canada, or from an osteopathic school approved by the American Osteopathic Association. Graduates of medical schools in other countries must either (1) be certified by the Educational Commission for Foreign Medical Graduates, or (2) have completed a Fifth Pathway program in an accredited school of medicine in the United States or Canada.

Graduate Education in Surgery (Prerequisite Training)

After receiving their medical degree, candidates must then: (1) complete a minimum of three years of clinical training in general surgery, with evidence of progressive responsibility in one program; OR (2) complete an accredited residency program in orthopedic surgery; OR (3) receive certification from the American Board of Otolaryngology.

Graduate Education in Plastic Surgery (Requisite Training)

Following the outlined prerequisite training, a residency in plastic surgery of no less than two years is required, with the final year devoted to senior-level responsibilities. Many plastic surgery residency programs are accredited for three years of training. If a candidate enters this type of program, the entire three years must be completed (also including one year at a senior level).

During these years of training, the resident must hold positions with increasing patient-care responsibility. Major operative experience and senior responsibility are essential to surgical education and training. An important factor in the development of surgeons is the supervised opportunity to grow in progressive, succeeding stages until they eventually assume complete responsibility for the surgical care of the patient. Another important characteristic of training in plastic surgery is that it covers the entire scope of the specialty. It includes experience in both the functional and aesthetic management of congenital and acquired defects of the head and neck, trunk and extremities.

The training also emphasizes the relationship of basic science -- including anatomy, pathology, physiology, biochemistry and microbiology -- to fundamental surgical principles. Finally, the training program must provide in-depth exposure to emergency care, treatment of shock, wound healing, blood replacement, fluid and electrolyte balance, pharmacology, anesthetics and chemotherapy.

Certification

The Board's written qualifying examination may be taken immediately after successful completion of a residency program in plastic surgery. However, the oral certifying exam may only be taken after successful completion of the written test and a two-year period of independent practice in plastic surgery.

The written qualifying examination consists of two parts. The first part is a three-hour, multiple-choice quiz covering the entire spectrum of clinical aesthetic and reconstructive surgery, as well as the body of related basic science principles. The second part is also multiple-choice and covers gross, microscopic and functional pathology, anatomy and embryology.

The oral certifying exam requires the submission of case reports prepared by the candidate while in active practice. The examination is designed to evaluate the candidate's breadth and depth of knowledge, and his or her ability to apply it in a wide range of clinical and ethical situations. Given in one day, the certifying test consists of: (1) a 45-minute oral review of eight major cases submitted by the candidate that are indicative of his or her work in the field of plastic surgery; and (2) a 45-minute oral exam on the theory and practice of plastic surgery, based on material prepared by the Board.

After the candidate has met the eligibility requirements for admissability and passed the written and oral examinations, a certificate attesting to his or her qualifications in plastic surgery is issued by the Board. A surgeon who is granted certification is known as a diplomate of the Board. It is the prerogative of the Board to determine the professional and ethical fitness of any candidate, and the Board, for cause, may defer or deny certification to any individual.

CONTINUING EDUCATION OF THE PLASTIC SURGEON

Compliance with minimum standards in continuing medical education (CME) is a requirement of all board-certified plastic surgeons. The programs for CME in cosmetic surgery are developed and supervised by the American Society of Plastic and Reconstructive Surgeons, Inc. (ASPRS), the Plastic Surgery Educational Foundation (PSEF) and the American Society for Aesthetic Plastic Surgery, Inc. (ASAPS). Certification by the American Board of Plastic Surgery is required for active membership in all three of these organizations. ASPRS and PSEF are open to all board-certified plastic surgeons, while ASAPS membership is open only to those whose practices are primarily cosmetic. Each of these organizations is international in scope and is dedicated to the promotion of optimal care for plastic surgery patients through education, research and maintenance of high professional standards.

ASPRS has established the CME requirements for plastic surgeons. These requirements parallel those of the American

Medical Association and many state medical societies. To satisfy these them, an ASPRS member must earn 150 credit hours of continuing medical education during a consecutive three-year period. Members failing to fulfill this quota are placed on probation for one year. If they fail to come into complicance within that time period, they are suspended from membership in ASPRS. They are then given one more year to complete the 150 hours, and their membership is automatically revoked if they are still short of their goal when the deadline expires. These CME requirements are listed in the ASPRS Bylaws, Article XIII, Sections 1 through 6.

The Plastic Surgery Educational Foundation develops and produces continuing education programs in conjunction with both ASPRS and ASAPS. These programs include:

1. Instructional Courses presented at the annual scientific meeting of ASPRS/PSEF on specific plastic surgery topics. These are presented by experts in the field and are comprehensive, didactic classroom situations. One hundred and fifty courses are presented annually at the scientific meeting, with approximately 25 percent devoted to aspects of cosmetic plastic surgery.

2. Clinical Symposia offered throughout the country. These are in-depth seminars, ranging in length from two to four days, during which participants have the opportunity to explore all aspects of an operation or subspecialty area. In the five-year period from 1984 to 1989, PSEF has sponsored, co-sponsored, or endorsed a total of 72 symposia. Of these, 42 focused

cosmetic surgery procedures, and 13 were co-sponsored with ASAPS. During these symposia, plastic surgeons share information on such areas as body sculpture, facial cosmetic surgery, ambulatory surgery, surgery for the aging face, aesthetic eyelid surgery, male cosmetic surgery, cosmetic surgery of the breast, rhinoplasty, occuloplastic surgery, secondary procedures in cosmetic surgery, and suction lipectomy.

3. Videoteleconferencing, which has been a major project of PSEF since 1985. In its Teleplast program, videos of actual surgeries are beamed via satellite to viewing sites across the country, and participants are able to call in questions to the featured surgeons. Twenty-two programs have been produced to date, with 50 percent of them concentrated on cosmetic surgery.

4. Videotapes documenting specific operative procedures and the latest techniques in reconstructive and aesthetic surgery. These are loaned or sold by the PSEF videotape library, with 110 tapes currently available. Of these, 60 are devoted specifically to aesthetic surgery topics.

5. Self-Assessment Examination, which is given annually to all residents in plastic surgery programs in the United States and Canada, and is offered to plastic surgeons in active practice. This examination comprehensively covers all aspects of plastic surgery, but 25 percent is specificially devoted to aesthetic surgery. The examination is graded and returned to the practicing plastic surgeon along with a critique and a syllabus discussing the answers in detail. This method of self-assessment

allows the practicing plastic surgeon to remain current in the important aspects of reconstructive and aesthetic surgery.

In addition, the American Society for Aesthetic Plastic Surgery, Inc., has sponsored an annual scientific meeting in each of the past 22 years. These programs have concentrated specifically on cosmetic surgery, providing members with complete instruction in all of the latest advances. For example, its annual meeting in 1989 will feature 54 scientific presentations and 60 instructional courses presented over a five-day period.

Opportunities for continuing medical education in the broad field of plastic surgery, and specifically in cosmetic surgery, are abundantly available to all board-certified plastic surgeons. The programs outlined above are constantly reviewed and re-evaluated in an effort to improve the quality of care delivered by practicing plastic surgeons, resulting in the overall benefit and safety of patients.

SUMMARY AND CONCLUSION

The education of a plastic surgeon is provided during a lengthy course of study in a specialized residency program, which is approved by the Accreditation Council for Graduate Medical Education and supervised by the Residency Review Committee. Certification in the specialty is earned by passing rigid examinations prepared by the American Board of Plastic Surgery -- one of 23 boards recognized by the American Board of Medical Specialties and the only board approved to provide certification in all aspects of plastic surgery. To remain current in their daily practice, plastic surgeons are required to complete programs of continuing medical education, including detailed courses of instruction in current topics of cosmetic surgery.

Because of these specific requirements for training, certification and continuing education, the plastic surgeon stands alone as the medical specialist best qualified to ensure the safety and satisfaction of patients undergoing cosmetic surgical procedures.

REFERENCES

1. Accreditation of Graduate Medical Education Program. Booklet of Information, produced by Accreditation Council for Graduate Medical Education, Chicago, IL 1989

2. Annual Report and Reference Handbook. The American Board of Medical Specialties. Evanston, IL 1988

3. Annual Scientific Program. American Society for Aesthetic Plastic Surgery, Inc. 1989

4. Booklet of Information. The American Board of Plastic Surgery, Inc. Philadelphia, PA. July 1, 1988 to June 30, 1989.

5. Continuing Medical Education Requirements of the American Society of Plastic and Reconstructive Surgeons, Inc. Bylaws and Code of Ethics for ASPRS. Arlington Heights, IL. 1988

6. Fox, C.G. and Graham, W.P. III. The American Board of Plastic Surgery, 1937-1987. Plast. and Reconstruct. Surg. 1982: 166-185, 1988

7. Product Catalogue. Plastic Surgery Educational Foundation. Arlington Heights, IL 1989

8. Shaping the Future of Medicine. Accreditation Council for Graduate Medical Education, Chicago, IL 1989

HOW TO SELECT A QUALIFIED PHYSICIAN: A PUBLIC SAFETY ISSUE.

Presented by

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April 4, 1989

Subcommittee on Regulation, Business Opportunities and Energy
Committee on Small Business
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The successful practice of medicine in this country has always been predicated on the integrity of the individual physician. In the past, widely accepted ethical standards have guided the professional conduct of physicians, and no degree of dishonesty or misrepresentation has been tolerated either by the medical profession itself or by society.

Unfortunately, changes in the way we live have greatly altered these traditional standards. In particular, a diminishing sense of personal integrity coupled with the anonymity of a highly mobile society have led to abuses on the part of some physicians who misrepresent themselves to the public and thereby violate the trust inherent in their professional status. Misrepresentation takes many forms and is so widespread among doctors today that the public can no longer assume the patient's best interests are being served simply because he is under the care of a licensed physician. The patient must take appropriate measures to protect himself and to assure that he is, in fact, in the hands of a qualified doctor.

The question is, how does one ascertain that a physician is, indeed, qualified to provide the type of care required?

Traditionally, patients have been advised to seek confirmation that the physician attended an accredited medical school, received applicable postgraduate training, and successfully completed the comprehensive peer review necessary for board certification in a particular medical specialty. There are 23 such specialty boards which are recognized by the American

Board of Medical Specialties (ABMS) and the American Medical Association Council on Medical Education (AMA/CME).

The candidate for certification by the American Board of Plastic Surgery has completed a long and difficult course of study following graduation from medical school. This includes three to five years of general surgery training, or postgraduate training in orthopedics or otolaryngology, prior to entering a two- to three-year residency program in plastic surgery. It is important to emphasize that the individual who enters a training program in plastic surgery has already completed the prerequisite training in general surgery. The plastic surgery resident already has extensive experience in evaluating the patient prior to surgery, managing the patient during major surgical procedures with loss of blood and body fluids, and caring for the patient following operative procedures.

For the individual going on to complete his plastic surgery training, the requirements include experience in the treatment and management of children with cleft lip and palate, major cancer procedures, reconstruction of the breast, management of burn patients, treatment of other injuries, as well as the precise techniques of aesthetic (cosmetic) surgery involving the face, eyes, nose, breasts and trunk. Successful completion of comprehensive written and oral examinations in all these areas is the final step to certification by the American Board of Plastic Surgery.

With this high level of training achieved by ABPS-certified plastic surgeons, why is the public in such grave danger of selecting an unqualified physician? The problem today is the existence of a wide variety of spurious credentials being promoted to the public as assurances of quality training, and this is causing increasing confusion among consumers of medical care. For example, the American Board of Cosmetic Surgery is not a board recognized by the ABMS, yet no one but a relatively sophisticated consumer will perceive the difference between that so-called "board" and the ABMS-approved American Board of Plastic Surgery. Members of the official-sounding body, the American Academy of Cosmetic Surgery, are not required to have any formal plastic surgery training but only to submit a list of 100 cosmetic procedures performed over a 12-month period. Certainly, membership in this organization provides the patient no legitimate assurance of quality care, yet the implication of specialized training is highly persuasive to the average consumer.

One of the primary means by which physicians today are blatantly misrepresenting their qualifications is through advertising. In many cases, the type of information provided by physician advertisements in no way reflects upon the quality of care which the patient can expect to receive. In fact, a large number of physicians use advertising as a vehicle for making statements which are solely intended to mislead patients. Advertisements may suggest that the physician is a plastic surgeon by training, when this is not the case. They may claim board-certification, while omitting direct reference to the certifying board. Or they may list credentials with official sounding names but with little or no substance. Thus the patient enters into a professional relationship with the physician based on a totally erroneous impression of that doctor's qualifications. Unfortunately, this type of deception is occurring on a very wide scale among physicians whose desire to perform cosmetic surgery is motivated solely by monetary considerations and not by issues of quality care for patients.

The situation exists today in which physicians are judged by the size and slickness of their advertisements, and not be meaningful criteria which could truly help prospective patients select a qualified doctor. Furthermore, patients are unaware of the communications tactics being employed not only to persuade them to undergo procedures for which they may or may not be appropriate candidates, but also to give them a false sense of comfort and trust in a physician whose training is not what it appears to be.

In one sense, then, "credentials" will not help the general public select a qualified physician unless they have sufficient knowledge to interpret these credentials. As long as most people are uninformed about what constitutes in-depth plastic surgery training, the importance of this training to their surgical outcome, and the significance of certification by the American Board of Plastic Surgery, they will continue to be misled by false and deceptive physician advertising. They will continue to think that certification by one board is as good as another and equally assures quality care. They will continue to believe that anyone calling himself a plastic surgeon is actually trained in the plastic surgery specialty. They will continue to find out the truth about unqualified physicians only when it is too late.

FTC officials say that the benefits of commercial advertising for surgical services outweigh the harm done to a few patients. However, the American Society of Plastic and Reconstructive Surgeons feels that human life and well-being are precious, and patients must be protected. It seems that the FTC policy only serves to promote a program of advertising that leads to uninformed choices and the performance of operations that are inappropriate or unsafe. To document that unfettered plastic surgery advertising creates confusion and misunderstanding among the general public, ASPRS is funding a scientific survey of randomly selected consumers, using different types of advertisements as tests. The results of this research, which is being conducted and coordinated by an independent consultant, will be reported to the FTC and to the Subcommittee on Regulation, Business Opportunities and Energy.

If advertisements are apt to be misleading about physician credentials, and the majority of qualified doctors still do not engage in advertising, then how does one go about finding a trained and competent plastic surgeon?

Articles in the lay press often instruct consumers to ask the physician direct questions aimed at discovering how much experience he or she has in a particular procedure, and to examine before and after photos of previous patients. These approaches may be helpful, to some extent, in determining the experience of the physician, and most plastic surgeons have many examples of their work to show prospective patients. However, it is common logic to assume that any doctor will show the best surgical results, not the worst. What still remains unknown to the patient is the depth of training which qualifies a particular doctor to perform the procedures in question; and it is depth of training alone which is the patient's best assurance of the doctor's ability to exercise appropriate judgment in any surgical situation, whether routine or dealing with unforeseeable complications.

Every human being has an intuitive sense, and patients should be encouraged to use their instincts when evaluating a doctor. If any physician does not provide honest, frank and thorough answers to questions posed by a prospective patient, this should be an important warning sign. If a physician does not voluntarily discuss both the benefits and risks of a surgical procedure, this should also be of concern to the patient. If a physician makes unrealistic statements or promises regarding the results of surgery, the patient should beware. However, the technical aspects of plastic surgery, or any medical specialty, are often difficult for the patient to understand and evaluate. In addition, a physician may be a very effective communicator, using a "slick" approach or various methods of persuasion which succeed in overcoming the patient's own better judgment. The qualified and honest physician will often appear less attractive to the patient when compared with this type of smooth-talking salesman. So, obviously, intuition is not enough when trying to select a qualified doctor.

Another avenue which is often suggested to patients seeking a qualified plastic surgeon is the recommendation of their family doctor. This can be a valid approach, but it, too, has major pitfalls. It has often occurred that a highly competent and conscientious physician has innocently referred a patient to a doctor known by his immediate colleagues to be disreputable. This is unlikely to occur if the referring doctor knows the other physician through a hospital or teaching institution affiliation which has required some form of credentialing and selective process. Nevertheless, it is surprising and sad to realize that many patients have fallen into the hands of unqualified doctors through the advice of a trusted physician.

The point of this discussion has been to show that the public is at significant risk when trying to select a qualified physician. The most reliable measure of competence remains appropriate education and certification by a medical specialty board approved by the American Board of Medical Specialties -- in the case of plastic surgery, certification by the American Board of Plastic Surgery.

The problem for the consumer is to separate fact from fiction, lies from truth, and meaningful credentials from spurious ones. Since this is a responsibility for which most of the public is unprepared, it is up to society to protect individuals from possible serious consequences, both physical and psychological, by establishing appropriate regulations which curtail the ability of physicians to misrepresent their qualifications.

HOSPITAL PEER REVIEW: THE MEASURE OF COMPETENCE

Presented by

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There is a nearly universal public perception that physicians are regulated by state or federal laws which define the training and qualifications of those who present themselves as specialists. If we are to appreciate the current problems which are surfacing in the field of aesthetic (cosmetic) surgery, we must start with a clear understanding that there are no such laws or regulations. There is, in fact, nothing to prevent any physician, regardless of training, from presenting himself as a plastic surgeon, a cosmetic surgeon, an aesthetic surgeon or any other designation which states or implies special qualifications. The average patient contemplating a surgical procedure is totally unaware of these uncertainties surrounding the very essence of quality care. In virtually every instance where these facts have been presented to the public, the response is predictably incredulous: "How can it be?"

The answer to this question lies in the fact that, until recently, physicians have done a credible job of self-regulation. The moral traditions and ethical standards of the medical profession have engendered a well-deserved trust in the basic edict that a doctor would never lie.

But times have changed. In plastic surgery, we have become aware that, today, there are physicians exploiting the public trust and endangering the public safety. These physicians openly and consistently make false and misleading claims regarding their training and qualifications to perform plastic surgery. This year, thousands of cosmetic surgical procedures will be performed by unqualified surgeons in unaccredited facilities. The quality of care which the patients of these doctors will receive is anybody's guess. How is this allowed to happen? The very existence of the unqualified surgeon operating in an unlicensed, unaccredited facility depends upon avoiding peer review.

The most meaningful assurance of quality control in plastic surgery is to subject the surgeon's training and experience to the scrutiny of other physicians, both surgeons and non-surgeons. Such scrutiny is called peer review, and it is best accomplished in hospitals by a credentialing process which has been used successfully for many years to assess the competence of every physician or surgeon proposing to practice in the hospital setting. In addition to an initial evaluation, peer review means that the quality of care provided by each staff physician continues to be monitored on an ongoing basis through quality assurance committees, utilization committees, tissue committees, and other similar bodies. These mechanisms are part of the daily operations of every accredited hospital in this country, and they are the best safeguard in preventing the unqualified from performing procedures for which they have inadequate training and experience.

As a board-certified plastic surgeon, I welcome the opportunity to have my qualifications examined. I am justifiably proud of my training, experience and the quality of care I provide for my patients. Through the peer review process, my credentials are not only examined by other plastic surgeons but also by a spectrum of specialists which may include neurosurgeons, ophthalmologists, cardiologists, orthopedists, endocrinologists, radiologists, and so on.

Contrary to the assertions of practitioners who wish to avoid the credentialing process, these committees are not for the purpose of limiting the rights of physicians to practice medicine; they do not serve to further the "monopolistic interests" of particular groups or to restrain trade. The peer review process, which is carried out by a diverse group of knowledgeable specialists who have no conflict of interest or prospects of secondary gain, is for the express purpose of insuring quality medical care.

There is a growing number of physicians and surgeons whose greed outweighs ethics and concern for patient well-being. They either refuse to accept the decision of their peers or avoid the peer review process altogether, realizing that they do not possess the training or experience to qualify for hospital privileges. Instead, they establish unlicensed and unaccredited surgical facilities in their offices, or build surgical clinics, and aggressively market themselves and their facilities to an unsuspecting public. The average medical consumer never realizes that these doctors do not meet the standards considered basic and essential by the medical community in order to practice the plastic surgery specialty in an accredited hospital.

The federal government has recognized the obvious importance of assuring that individuals who are responsible for public safety must meet stringent requirements. Air travel is a good example. Only those who are sufficiently qualified to pilot 747's are permitted to do so. The public deserves this protection. Unfortunately, in medicine we have physicians who have no more training than Piper Cub pilots telling the public that they can fly 747's, and there is absolutely no state or federal law that prohibits them from doing so.

This deception is allowed to continue because individuals succeed in avoiding the hospital credentialing process. When the issue of quality is raised with these particular physicians, they will always try to direct attention away from quality and to argue that the real issue is some sort of "turf battle."

An otolaryngologist who operates on a woman to increase the size of her breasts is acting in direct opposition to the American Board of Otolaryngology, which states that such procedures are not within his field of training. He is not performing the procedure from the standpoint of providing a service which is otherwise not available or accommodating the needs of a population which is underserved. He is doing it for the express purpose of personal financial gain, and in order to carry out his plan, he must deceive the public into believing he is a "plastic surgeon."

Physicians who perform aesthetic procedures for which they cannot obtain hospital privileges fail, in a very real sense, to meet a community standard. Knowledgeable physicians who are responsible members of hospital credentialing committees recognize the training and qualifications necessary to perform various surgeries, and they will not permit the unqualified to undertake such procedures.

Legislation is urgently needed which will be directed at those who purposely avoid and deny the peer review standards governing the delivery of quality medical care. These physicians must be required to meet the same standards of training and qualifications that the public expects of hospital-based surgeons. Even if a practitioner intends to perform surgical procedures outside of the hospital setting, the public deserves the assurance that the physician does meet hospital standards and that, if the patient so desired, the physician would be permitted to perform the same procedure in an accredited hospital.

What sort of protection is afforded to the public when a physician who fails to meet hospital standards can remove himself from the hospital setting, set up an unlicensed and unaccredited facility, and represent himself as a specialist in a specialty for which he cannot obtain privileges at a hospital?

The issue is quality care. Peer review is a process which is accepted by every legitimate medical specialty. The day of self-proclaimed specialists must be over, and a new era of concern for public safety must be instituted by meaningful legislation to require every physician claiming to be a specialist to meet hospital standards for that specialty.

ADVERTISING IN PLASTIC SURGERY:
A POSITION PAPER

Presented by

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Subcommittee on Regulation, Business Opportunities and Energy
Committee on Small Business
U.S. House of Representatives

In December 1975, the Federal Trade Commission filed a complaint against the American Medical Association based on the theory that by restricting members from advertising, it was guilty of anti-competitive practices. It was an article of faith of the chief commissioner at the time, Mr. Michael Pertschuk, that advertising would stimulate competition and thus bring down the cost of medical care.

In 1978, the American Society of Plastic and Reconstructive Surgeons was presented with a proposed complaint and consent decree alleging the use of board certification for anti-competitive purposes. We tried by every conceivable means to convince FTC officials that:

A) Such actions would open a Pandora's box -- resulting in wholesale, serious injury to the public -- since it would strongly encourage those whose greed exceeds their scruples.

B) Removal of controls on physician training and advertising would totally emasculate any disciplinary control medical organizations have over their members.

C) The agency's premise was incorrect, since the forces that shape the marketplace in general do not apply to medicine -- regardless of what the "Economics 101" texts say.

D) The FTC was wandering out of its jurisdiction, since we were not arguing about a product but a specialized, highly individualized service that should be denied rather than encouraged for certain individuals.

The consent decree presented to ASPRS was extensively negotiated but never accepted.

As expected, the last 10 years have brought on a virtual explosion of advertising by all kinds of practioners who are performing cosmetic surgery. Some advertisers are completely unqualified in plastic surgery, having received their formal training in a field totally unrelated to the specialty. Others have received acceptable training in certain plastic surgery procedures, but advertise their willingness to perform operations that fall well outside their documented expertise.

Unfortunately, it is almost impossible for consumers to distinguish between these physicians and fully trained and certified plastic surgeons. Regardless of the fact that they actually received their formal training as an otolaryngologist, dermatologist, gynecologist or other unrelated specialist, these individuals routinely label themselves "plastic surgeons." Those who received certification in their original specialty give themselves a greater veneer of credibility by describing themselves in their ads as "board-certified" -- even though their certificate is not from the American Board of Plastic Surgery, the only body authorized by the American Board of Medical Specialties to certify plastic surgeons.

The average consumer assumes that the federal and state governments are watching out for the public, and that a physician would not be able to call himself a plastic surgeon if he had not completed an extensive program of approved training in that specialty. The average consumer also assumes that if a physician calls himself "board-certified," he has been certified in the specialty for which he is advertising. Even those sophisticated enough to question this claim, or to look for an ad that names the specific board, may still be misled when they are simply told the doctor has been tested by the "American Board of Cosmetic Surgery." With a name that sound interchangeable with the American Board of Plastic Surgery, consumers have no way of knowing that the Cosmetic Board is a different entity, that it is not recognized by the American Board of Medical Specialties, and that it does not require its applicants to complete an accredited residency program in plastic surgery. (As Dr. Noone outlined in his paper, there is no such thing as an accredited residency program in cosmetic surgery.)

This country is filled with unhappy, credulous people "in search of themselves." On one day, they may respond to a well-written ad for spiritual renaissance or astrology, while on the next day they may be vulnerable to a well-produced advertisement urging that "you owe it to yourself to discover the new you" by getting a new nose, or a larger pair of breasts. If physicians continue to be allowed to practice any specialty they wish as long as they have a general medical degree, then the only way to protect consumers is to give them the facts they need to make an informed choice of practitioner.

ASPRS has called on the FTC to require any advertiser claiming to be "board-certified" to name by which board he or she has been tested. In addition, if that board is not recognized by the American Board of Medical Specialties, then that fact should be clearly stated. Requiring physician advertisers to divulge the true nature of their formal training will not hinder fair, honest competition.

As the growth of advertising for cosmetic surgery continues, we have begun to see and document an alarming rise in the number of catastrophic surgical results, including deaths. We are convinced these problems will become far worse and increase in number. Consumers who are conditioned to hard-sell advertising techniques do not understand the difference between advertisements designed to assist the public in obtaining medical services and those that, in the words of Chief Justice Hughes, "would prey upon a public particularly susceptible to imposition through alluring promises of physical relief."

Prospective patients should always select any doctor on an informed basis. Traditionally, this information has taken the form of recommendations from other physicians, medical societies, friends, relatives and so on. When such advice is lacking, and when prospective patients correctly seek additional information, disclosure of facts about a physician's training and his or her practice are clearly helpful.

Of course, ASPRS is the first to agree that deceptive advertising is not limited to claims about training, and can therefore be practiced by genuine plastic surgeons as well. We consider soliciting patients through false and deceptive advertising to be a particularly grave danger within our field. Advertising that suggests a particular plastic surgical operation is magically beneficial, painless or simple without clearly spelling out the risks involved cannot be condoned. We feel strongly that ads designed to persuade uninformed and credulous laypersons to undergo elective surgical operations that may not even be appropriate for them is not in the public interest. Many operations in the field of cosmetic plastic surgery are undoubtedly beneficial both psychologically and physically for given individuals, while the same operations may have a disastrous effect on others.

One of the most important functions of surgeons is to evaluate prospective patients for physical and psychological suitability and to counsel them impartially. This function is virtually incompatible with advertising that is primarily designed to "sell" unneeded and unwanted operations before an initial consultation is held between patient and doctor. Such advertising, implying that near magical changes in patients' lives are not only possible but probable, is flourishing in all states in the union.

The FTC's belief that widespread commercial advertising would cause a general decrease in the cost of plastic surgery services was, as predicted, totally unfounded. The interpretation of signals coming from Washington had quite the opposite effect. One doctor in California who widely advertises the universally beneficial effects of cosmetic surgery has spent more than $175,000 over a six-month period for advertising in one newspaper alone. It is estimated that his multi-media campaign throughout Southern California must be costing at least $750,000. This expenditure represents only one individual and there are a number of physicians advertising their plastic surgery services. Where will this large amount of money come from if not from patients' pockets? As other plastic surgeons respond to this type of massive advertising campaign with equally expensive reports of their own, the average surgical fee is rising significantly.

All else aside, we fully recognize the dangers of pointing fingers and emphasizing the complications and unfavorable results of other doctors. We believe, however, that these dangers are far outweighed by positive results. First, and most important, is the benefit to the public. There is an incessant barrage of articles or broadcasts in the media, often generated by paid public relations efforts, that tout unbelievable new advances or exclusive new techniques. These are often simply baited traps for prospective patients rather than reports of truly new surgical techniques. This has forced our society -- primarily a scientific and educational organization -- into a role akin to that of a consumer protection agency.

Secondly, as the medical director of the largest malpractice insurance carrier in the West, I can assure you that the computers of the insurance industry are not programmed to distinguish between the trained and the untrained or the scrupulous and the unscrupulous. We fear that if some control is not exerted, the expanding sphere of litigation will adversely affect insurance premiums throughout the specialty.

Anyone who does surgery and claims to never have any complications is a liar, is inexperienced or has a pact with the devil. In the best of hands, complications will occur.

However, the one feature that many disastrous results have in common is an absolute lack of discriminatory judgment. Often, the only pre-operative criteria used in these cases were a normal temperature and a valid credit card.

The American Society of Plastic and Reconstructive Surgeons sees a qualitative difference between an advertisement that states the identity, specialty training, board certification, office hours, special areas of interest, etc. of a physician, and one that is misleading and designed to seduce unsophisticated individuals into believing that cosmetic operations will produce magical changes in their lives.

Legitimate plastic surgery societies believe that even in these changing times, clear parameters can and should be established for advertising by physicians. Although we understand that such guidelines are basically state functions, we are alarmed by the appalling slowness with which appropriate responses are being developed. We hope that the official government agencies, both at the state and federal levels, agree with us that it is harmful to the public to create inflated or unjustified expectations of favorable results; make statements that imply a physician has skills superior to others, unless such skills can be factually substantiated; or use incorrect, incomplete or misleading information that is likely to cause the average person to misunderstand or be deceived. We also hope the government agrees with us that it is the ethical duty of a physician to subordinate financial reward to social responsibility.

It is somehow paradoxical that the heart of our case should lie in a statement made by Chief Justice Burger of the Supreme Court in the Virginia Pharmacy Decision. In language far more eloquent and majestic than we can muster, Mr. Justice Burger stated, "I think it important to note. . .that the advertisement of professional services carries with it quite different risks than the advertisement of standard products."

Justice Burger then quoted approvingly the following excerpt from an earlier Supreme Court decision prohibiting certain types of advertising by dentists:

"The legislature was not dealing with traders in commodities, but with the vital interests of public health, and with a profession treating bodily ills and demanding different standards of conduct from those which are traditional in the competition of the marketplace. The community is concerned with the maintenance of professional standards which will insure not only competency in individual practitioners, but also protection against those who would prey upon a public peculiarly susceptible to imposition through alluring promises of physical relief. The community is (also) concerned with providing safeguards not only against deception, but against practices which would tend to demoralize the profession by forcing its members into an unseemly rivalry which would enlarge the opportunities of the least scrupulous."

It is evident to us that although it ruled in favor of professional advertising, the Supreme Court of the United States still understood what we feel is at stake. If restrictions and prohibitions on unscrupulous, deceptive advertising are not imposed, the public will respond only to the most costly and excessive displays and end up paying the price. Those physicians who have proven their eagerness to take up the huckster's banner have lost no time in taking advantage of the confusion that exists, thus bringing to life the Supreme Court's vision: "an unseemly rivalry, which would enlarge the opportunities of the least scrupulous."

One hears from FTC officials the opinion that the public benefits of commercial advertising for surgical services outweigh the harm done to a few patients. The American Society of Plastic and Reconstructive Surgeons feels that human life and well-being are precious, and that patients must be protected. It seems to us anomalous to promote a program of advertising that leads to the performance of operations that are inappropriate.

The American Society of Plastic and Reconstructive Surgeons is prepared to document its stand in favor of limits on professional advertising with tragic examples of the human cost of lack of control. These are people who see an ad, respond to it and pay for their innocence the rest of their lives. These are women who ask us with tears in their eyes, "How can this kind of thing be allowed?" The American Society of Plastic and Reconstructive Surgeons asks the same question.

DONALD L. WEISSMAN, M.D., F.I.A.C.S.

COSMETIC & RECONSTRUCTIVE
SURGERY

The Weissman Institute
9701 Sunset Boulevard, Suite 605
Los Angeles, California 90069

(213) 271-1162

Congressman Ron Wyden
Chairman
Small Business Subcommittee on
Regulation, Business Opportunities,
and Energy

OPENING ADDRESS

Congressman Wyden, Congressman Bloomfield and Members of the Committee:

I want to take this opportunity to thank you for permitting me and Mr. Robert K. Tanenbaum, my attorney, to appear before you to give testimony. The purpose of my appearance is to set the record straight with regard to my competence, training, and experience as a cosmetic surgeon and to respond to the false and defamatory impressions about me contained in a program viewed by some of the members of this committee.

My understanding is that this committee is concerned with the quality, competence, and manner in which cosmetic surgery is performed in America today. I share that concern as well.

However, you must understand that no congressional committee or media producers have the right to defame American citizens. A distorted, unbalanced presentation of me has been presented to you. With your indulgence, I will now respond.

I believe that I am a highly qualified, skillfully trained, and successfully accomplished cosmetic surgeon. The good faith basis for my belief is founded upon the following:

1. I completed formal training and chief residency in head and neck, ear, nose and throat/facial plastic and reconstructive surgery;
2. My year as chief resident was completed at Case Western Reserve University;
3. I spent thousands of hours as an Emergency Room Physician directing emergency room facilities. In so doing, I personally engaged in the diagnosis and acute care of virtually every sort of medical and surgical emergency.
4. I spent two years in a preceptorship/mentorship with Dr. Alfred Koonin, a Board Certified Plastic Surgeon, and Dr. Steve Gottlieb, a Board Eligible Plastic Surgeon, learning and performing cosmetic surgery.
5. During the last five years, I have treated thousands of patients and performed thousands of surgeries.

During the same period of time, I have been invited to lecture and present papers before national and international meetings and seminars including, but not limited to:

1. The World Congress on Facial Sculpting in Cosmetic Surgery, sponsored by the American Academy of Cosmetic Surgery, "Correction of Microgenia with Alloplastic Augmentation and Liposuction", Atlanta, Ga., October 1987.

2. The Foundation for Facial Plastic Surgery, "Rhinoplasty and Proplast Implants", Newport Beach, Ca., August 1986.
3. The American Academy of Cosmetic Surgery, co-sponsored by The International Oculoplasty Society and The American Society of Liposuction Surgery, The First World Congress on Dermabrasion, Chemical Peel, Liposuction and Soft Tissue Augmentation - "Refinements in Liposuction Surgery", and "Skin Excisions Combined with Chemo-Dermal Exfoliation for Acne and Traumatic Scarring", New Orleans, La., October 1986.
4. Faculty and Panel Discussion - American Academy of Cosmetic Surgery Symposium; Breast Augmentation; "Submuscular Versus Subglandular Breast Augmentation: Pros and Cons" and "Complications of Augmentation Mammoplasty: Their Prevention and Treatment", Houston, Tx., August 1986.
5. The Twenty-Fourth Annual Meeting of the International Society of Aesthetic Surgery, Chairman, Section meeting on Malar and Nasal Implants - "Liposuction: The Current State of the Art", "Breast Augmentation: The Areolar Approach" and "Rhinoplasty: Augmentation and Reduction", Tokyo, Japan, May-June 1985.
6. The First International Congress of The American Academy of Cosmetic Surgeons - "Rhinoplasty in the Non-Caucasian" and "Mammoplasty in the Non-Caucasian", San Francisco, Ca., September 1985.

7. And most recently at the American College of Legal Medicine 29th International Conference, "Informed Consent and Cosmetic Surgery", Palm Springs, Ca., March 1989.

I am a contributing co-author of a book entitled Body Contouring Through Liposuction Surgery, Keith Terry and Associates, Irvine, Ca., 1986.

In late May of 1986, I terminated the employment of one of my employees who, without my permission or authority, and in violation of my patients' rights of confidentiality, I have a good faith reason to believe, removed from my office information contained in my patient lists and some of my patient records. These stolen materials were subsequently given to state authorities who regrettably ratified this theft and randomly called my patients inquiring of them in substance if I had been unprofessional, and/or whether I had engaged in some kind of misconduct, and whether they were satisfied with my surgery. As a result of this official misconduct, coupled with the intervention and urging of a plastic surgeon, I presently am responding to five civil lawsuits out of the thousands of patients that I have attended and on whom I have performed successful cosmetic surgery.

Now with regard to the Program entitled "For the Sake of Appearances," hereinafter referred to as "the Program," which I have been informed has been viewed by several of the members of this committee and which has been disseminated to you by the American Society of Plastic Surgeons. The Program has created and disseminated false and defamatory impressions about me.

Specifically, it wrongfully states that I am not trained or experienced in my specialty, cosmetic surgery, and that I refused to be interviewed on their Program. I wish to inform this committee that I was indeed interviewed and desired to have my point of view heard. I was as forthcoming with the producer of that program as I am with you. For some reason unknown to me, there was not one word uttered on that Program voicing my side or point of view, and yet there was specific reference to the fact that I refused to be interviewed. Furthermore, the program presents a former patient of mine who claims, among other things, that she presently has difficulty raising above her shoulder her left arm. I have with me today for your scrutiny medical documentation that will absolutely and unequivocally refute this claim. Moreover, public records on file in the Country Clerk's Office in Los Angeles reveal that she was charged with felonious grand theft, a violation of penal code Sec. 487(1), two counts, filed on September 29, 1982 in the Superior Court of Los Angeles, Case No. A378222. These records further indicate that she pleaded no contest to one count of the Information on December 14, 1982 before the Honorable Ricardo A. Torres.

Also on December 14, 1982, this individual, among conditions of her sentence, was ordered by the Court to make restitution, which I have reason to believe, to this date, has not been made.

Finally, I wish to submit to you a copy of my Curriculum Vitae, listing my educational and professional background, which I have just briefly summarized for you, and hope that it will shed further light on my qualifications and professionalism. I also want you to know that I would welcome a visit by any of you to my offices so that you can see the superb quality of my facility and professionalism that I and my staff bring to it.

Thank you very much.

April 4, 1989

RIORDAN & McKINZIE
A PROFESSIONAL LAW CORPORATION

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FILE NO.

ROBERT K. TANENBAUM
DIRECT DIAL
(213) 229-8524

March 28, 1989

Congressman Ron Wyden
Chairman
Small Business Subcommittee on Regulation,
Business Opportunity and Energy
Rayburn House Office Building, Room 2452
Washington, D.C. 20515

Congressman William Broomfield
2306 Rayburn House Office Building
Washington, D.C. 20515

Re: Donald L. Weissman, M.D.
Request for Appearance before the Committee

Dear Congressmen:

This office represents Dr. Donald L. Weissman. We have reason to believe that on or about October 31, 1988, a tape addressing plastic surgery was aired on television and has been seen by some members of your committee. The program made specific reference to our client and incorrectly stated, inter alia, that Dr. Weissman was unfit to perform cosmetic surgery, injured a patient, Donna Barone, and refused to be interviewed.

The program has created and disseminated false and defamatory impressions about Dr. Weissman. Careful scrutiny will reveal that Dr. Weissman is an outstanding surgeon, trained and experienced in, not only ear, nose and throat, but also in his present specialty, cosmetic surgery. He has performed thousands of successful cases, not only with competence, but with praise from his patients. The individual who appears on the tape, Donna Barone, who represents herself as a professional model, and who claims that she lost full use of her arm, is disingenuous in the extreme.

There is no evidence to suggest that she was ever a model, professional or otherwise, and medical documentation exists that demonstrates that her claim of injury to her arm is a fabrication. Moreover, public records on file in the County Clerk's office indicate that she has been convicted of embezzlement, based upon the filing of felonious grand theft charges, penal code § #487(1), two counts, filed on September 29, 1982 in the Superior Court of Los Angeles, Case No. A378222. She pleaded no contest to one count of the Information on December 14, 1982 before the Honorable Ricardo A. Torres.

Also, the probation hearing was held on December 14, 1982, wherein Ms. Barone, among conditions of her sentence, was ordered to make restitution, which we have reason to believe, to this date has not been made.

With respect to the defamatory comment that Dr. Weissman refused to be interviewed, the record is totally to the contrary. Not only did Dr. Weissman's lawyer speak with the Producer, Claudia Bryant, but, precisely on point, Dr. Weissman in truth and in fact was indeed interviewed. Statements to the contrary create a negative, false, and unfavorable impression upon Dr. Weissman's character and ability to practice his chosen profession. Unquestionably, the clear inference that Dr. Weissman "refused to be interviewed" is that he must be therefore "guilty," otherwise, he certainly would have appeared on screen.

Having worked for the Congress, I know that you are concerned with presenting a fair and complete portrayal of events, depicting accurately a factual scenario. Therefore, please take notice that if it is your intention to hold public hearings and/or any other depiction of Dr. Weissman, I, on behalf of Dr. Weissman, request that we appear before your committee to refute these outrageous unfounded charges. We can agree that the Congress of the United States should avoid taking sides in an internecine battle between Los Angeles and California Boards of Plastic Surgeons and Cosmetic Surgeons. Subsequent judicial hearings will reveal that this entire issue is nothing more than a vendetta by plastic surgeons trying to defame, unjustly accuse, and economically take advantage of their competitors--cosmetic surgeons.

Dr. Weissman presently faces accusations which are pending and unproven. Dr. Weissman has every reason to believe that he will be completely exonerated, but that will mean precious little if he is publicly defamed by your committee. The rudiments of procedural due process cry out for his side to be heard. I anxiously await your response and thank you for your consideration in this matter.

Sincerely,

Robert Tanenbaum

Robert K. Tanenbaum
of RIORDAN & McKINZIE

RKT:dm

cc: Donald L. Weissman, M.D.

101st Congress

ELIOT L. ENGEL, NEW YORK
NORMAN SISISKY, VIRGINIA
JIM OLIN, VIRGINIA
MICHAEL R. McNULTY, NEW YORK

United States House of Representatives
Committee on Small Business
Subcommittee on Regulation,
Business Opportunities, and Energy
B-363 Rayburn House Office Building
Washington, DC 20515

[illegible] D. HANCOCK, MISSOURI

STEVE JENNING
SUBCOMMITTEE STAFF DIRECTOR
[illegible]

ANDREW POWELL
MINORITY SUBCOMMITTEE PROFESSIONAL
STAFF MEMBER
[illegible]

March 29, 1989

Dr. Donald Weissman
9201 Sunset Boulevard
Suite 605
Los Angeles, California

Dear Dr. Weissman:

I am in receipt of the March 28, 1989, letter from Mr. Robert Tanenbaum of RIORDAN & McKINZIE, who represents himself as your attorney.

As you already know, the Subcommittee on Regulation, Business Opportunities and Energy is examining the current explosion in the number of cosmetic surgery procedures being performed nationwide. The subcommittee is deeply concerned that in many cases cosmetic surgery is being performed by less than fully qualified doctors, and in many cases at totally inadequate facilities.

At your attorney's request, you will be received to present your testimony at the subcommittee's hearing on April 4, 1989, to address the concerns expressed in Mr. Tanenbaum's letter.

To ensure that the hearing progresses in a timely manner, witnesses are asked to limit their summary remarks to less than ten minutes. A written statement of any length, however, may be submitted for the hearing record. Though we traditionally request 25 copies of testimony in advance of the hearing, for your convenience you may FAX one copy to my office at (202) 225-8941. Please provide 100 copies of your statement at the hearing for distribution by subcommittee staff.

The hearing is scheduled to begin at 10 a.m., Tuesday, April 4, in Room 2359A, the Rayburn House Office Building, Washington, D.C.

Should you have any questions, please contact Frank Papineau or D.Ann Murphy of the subcommittee staff at (202) 225-7797.

Sincerely

Ron Wyden

RON WYDEN
Chairman

cc: Mr. Robert K. Tanenbaum
The Honorable William Broomfield

JOHN K. VAN DE KAMP, Attorney General
of the State of California
STEPHEN S. HANDIN,
Deputy Attorney General
3580 Wilshire Boulevard, Suite 800
Los Angeles, California 90010
Telephone: (213) 736-2130

Attorneys for Complainant

BEFORE THE
DIVISION OF MEDICAL QUALITY
BOARD OF MEDICAL QUALITY ASSURANCE
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: DONALD L. WEISSMAN, M.D. 9201 Sunset Blvd., Suite 605 Los Angeles, CA 90069 Physician and Surgeon Certificate No. A031649, Respondent.	NO. D-3739 ACCUSATION

Complainant, Kenneth J. Wagstaff, alleges as follows:

1. He is the Executive Director of the Board of Medical Quality Assurance (hereinafter the "board") and brings this accusation solely in his official capacity.

2. On or about October 13, 1977, the board issued physician's and surgeon's certificate number A031649 to Donald L. Weissman, M.D. (hereinafter "respondent"). Said certificate has since been in full force and effect.

3. Sections 2004 and 2220 of the Business and Professions Code (hereinafter the "code") empower the Division of Medical Quality Assurance (hereinafter the "Division") of the board to enforce and administer the disciplinary provisions of the Medical Practice Act (§ 2000 et seq. of the code) as they apply to physicians and surgeons.

4. Section 2234 of the code requires the Division to take disciplinary action against any physician and surgeon who has engaged in unprofessional conduct which includes but is not limited to the violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provision of the Medical Practice Act (subd. (a)), gross negligence (subd. (b)), repeated negligent acts (subd. (c)), incompetence (subd. (d)), and the commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon (subd. (e)).

5. Section 2261 of the code defines unprofessional conduct as knowingly making or signing any certificate or other document directly or indirectly related to the practice of medicine which falsely represents the existence or nonexistence of a state of facts.

6. Section 2262 of the code defines unprofessional conduct as altering or modifying the medical record of any person, with fraudulent intent, or creating any false medical record with fraudulent intent.

7. Section 2263 of the code defines unprofessional

conduct as the willful, unauthorized violation of a professional confidence.

8. Section 2271 of the code defines unprofessional conduct as any advertising in violation of section 17500 of the code relating to false or misleading advertising.

9. Section 2285 of the code defines unprofessional conduct as the use of any fictitious, false, or assumed name, in any public communication, advertisement, sign or announcement, without having obtained a fictitious name permit pursuant to section 2415 of the code.

10. Section 810(a) of the code defines unprofessional conduct as: (1) knowingly presenting or causing to be presented any false or fraudulent insurance claim, or (a) knowingly preparing, making, or subscribing any writing with intent to present or use the same, or to allow it to be presented or used in support of any such claim.

11. Section 726 of the code defines unprofessional conduct as the commission of any act or sexual abuse, misconduct, or relations with a patient.

12. Pursuant to section 651(g) of the code, it is cause for discipline for a physician and surgeon to engage in false, fraudulent, misleading, or deceptive advertising within the meaning of section 631 of the code.

13. Respondent's certificate of licensure is subject to discipline, as more specifically alleged below :

Donna Baron

D.B. 1/

A. On or about July 2, 1985, respondent undertook the care and treatment of D.B., a 31-year old female seeking breast augmentation surgery. On or about August 15, 1985, respondent biopsied both breasts and performed a cosmetic surgical procedure upon the patient's breasts with unsatisfactory results, including breast asymmetry. On or about August 28, 1985, a closed capsulotomy of the left breast was performed. On or about September 13, 1985, respondent performed further surgery in an attempt to correct the patient's breast asymmetry, and on or about October 15, respondent performed further surgery in an attempt to correct scarring of the patient's left nipple.

(1) Respondent's care and treatment of D.B. was grossly negligent, repeatedly negligent and incompetent, in violation of sections 2234(b), (c) and (d) of the code in that:

(a) Respondent's records contain no anesthesia record for the September 13, 1985, surgery and no operation report for the October 15, 1985, surgery.

(b) Respondent's records for the August 15, 1985, surgery fail to specify the quadrant within the breasts from which the biopsy tissue samples were taken.

(c) The intervals between surgeries were too

---

1. Patients will be referred to herein by initials only. Their full identity will be provided in response to an appropriate discovery request.

short.

(d) The surgeries resulted in breast and nipple asymmetry, deformation and scarring, numbness of the left breast, and loss of mobility in the left arm.

(2) Respondent was grossly negligent, repeatedly negligent and engaged in acts of sexual abuse and misconduct with a patient in violation of sections 2234(b) and (c) and 726 of the code, in that during the course of the patient's office visits with respondent, he made sexual advances and innuendoes, including telling the patient he would make her breasts look so good she would "want to give them to me." On another occasion when the patient and her boyfriend were in respondent's office, respondent had the patient lie face down on the floor to demonstrate exercises. Respondent commented to the boyfriend that when the patient was in this position, he (the boyfriend) could "get her from behind." On another occasion respondent pulled the patient toward him, tried to kiss her, and when she turned her head, he stuck his tongue in her ear and suggested they get down on the floor and have sexual intercourse. On another occasion, respondent told the patient that he would not correct the bad surgical results unless she had sexual intercourse with him. On another occasion, respondent tried to kiss the patient on the lips. When she pushed him away, he took her hand and put it on his hard penis and said, "see what you do to me." On still other occasions, respondent asked the patient how her sex

life was, and asked her to come see him in his office after hours.

(3) Respondent made and/or signed a false medical document, and presented or caused to be presented false or fraudulent insurance claims in violation of sections 2234(e), 2261, 2262 and 810(a) of the code, in that his operation report for the August 15, 1985, surgery, which was submitted to the Teamsters Miscellaneous Security Fund in support of an insurance claim, stated that the patient was "complaining of lumps in both breasts and considerable pain," when in fact she had not so complained.

M.M.

B. On or about November 27, 1985, respondent undertook the care and treatment of M.M., a 42-year old female seeking breast augmentation surgery and blepharoplasty. The patient, under the care of another physician, had previously undergone breast augmentation surgery and had drooping, abnormally shaped breasts. On or about December 12, 1985, respondent replaced both breast implants, biopsied both breasts, and performed bilateral upper lid blepharoplasty. On or about January 7, 1985, respondent performed a bilateral closed capsulotomy. On January 22, 1986, respondent performed an open capsulotomy of the right breast.

(1) Respondent's care and treatment of M.M. was grossly negligent, repeatedly negligent and incompetent in violation of sections 2234 (b), (c) and (d) of the code in

that respondent's records for the December 12, 1985, surgery failed to specify the quadrant within the breasts from which the biopsy tissue samples were taken.

(2) Respondent was grossly negligent, repeatedly negligent and engaged in acts of sexual abuse and misconduct with a patient in violation of sections 2234 (b) and (c) and 726 of the code in that during the course of the patient's office visits responded kissed the patient, sucked on her nipples, made her feel his hard penis and asked her if she wanted to have sexual intercourse with him.

(3) Respondent made/and or signed false medical documents and presented or caused to be presented a false or fraudulent insurance claim in violation of sections 2234(e), 2261, 2262 and 810(a) of the code, in that his operation report for the December 12, 1985, surgery, which was submitted to the Massachusetts Mutual Life Insurance Company in support of an insurance claim, made no mention of the bilateral upper lid blepharoplasty. Respondent's office progress notes submitted to the insurance company similarly made no mention of the procedure on December 12, 1985, yet a copy of the progress notes provided to the board's investigator contained an entry referencing the procedure. Respondent also noted in the December 12, 1985, operation record and in a November 27, 1985, progress note entry that the patient presented, complaining of bilateral breast pain, when in fact she made no such complaint.

Respondent billed the insurance company for "multichannel reports" in connection with the January 7, 1985, procedure. Yet there is no record of any multichannel monitoring having been performed.

C.W.

C. On or about June 3, 1986, respondent undertook the care and treatment of C.W., a 24-year old female seeking breast augmentation surgery. On or about June 20, 1986, respondent performed breast enlargement surgery and rhinoplasty.

(1) Respondent was grossly negligent, repeatedly negligent and engaged in acts of sexual abuse, misconduct and relations with a patient in violation of sections 2234 (b) and (c) and 726 of the code, in that during the course of C.W.'s office visits, respondent placed the patient's hand on his hard penis and attempted to massage her pubic area. Respondent kissed the patient on her lips and breasts and had the patient orally copulate him and have sexual intercourse with him.

(2) Respondent made and/or signed false medical documents and presented or caused to be presented a false or fraudulent insurance claim in violation of sections 2234(e), 2261, 2262 and 810(a) of the code, in that the operation report for the June 20, 1986, rhinoplasty, which was submitted to the Mutual Benefit Life Insurance Company in support of an insurance claim, and the office progress notes for June 3, 1986, stated that the patient presented,

complaining of an inability to breathe through her nose because of an accident, wherein she had fallen down stairs a month previously, injuring her nose. The patient in fact made no such complaint and was concerned only with the cosmetic appearance of her nose.

B.B.

D. On or about April 29, 1985, respondent undertook the care and treatment of B.B., a 27-year old female complaining of difficulty breathing through her nose. The patient subsequently agreed to have breast augmentation surgery. On or about June 19, 1985, respondent performed breast augmentation surgery upon the patient and biopsied both breasts. On or about July 10, 1985, respondent performed nasal surgery upon the patient.

(1) Respondent's care and treatment of B.B. was grossly negligent, repeatedly negligent and incompetent in violation of sections 2234(b), (c) and (d) of the code, in that respondent's records for the June 19, 1985, surgery fail to specify the quadrant within the breasts from which the biopsy tissue samples were taken.

(2) Respondent was grossly negligent, repeatedly negligent and wilfully violated a professional confidence in violation of sections 2234 (b) and (c) and 2263 of the code, in that he took photographs of the patient showing both her face and bare breasts after promising not to do so and then displayed said photographs to others.

(3) Respondent made and/or signed false medical

documents and presented or caused to be presented a false or fraudulent insurance claim in violation of sections 2234(e), 2261, 2262 and 810(a) of the code, in that one of two operation records for the June 19,1985, surgery which were submitted to the Screen Actors Guild-Producers Pension & Health Plan in support of an insurance claim stated that a bilateral subcutaneous mastectomy with immediate reconstruction was performed, when in fact the procedure performed was an elective breast augmentation surgery for cosmetic purposes only, and the office progress notes for April 29, 1985, state that the patient had fallen down stairs a month previously, injuring her nose, when in fact such was not the case.

B.V.

E. On or about August 7, 1984, respondent undertook the care and treatment of B.V., a 23-year old female complaining of difficulty breathing through her nose. On or about September 11, 1984, respondent performed nasal surgery including reconstruction.

(1) Respondent's care and treatment of B.V. was grossly negligent, repeatedly negligent and incompetent in violation of sections 2234 (b), (c) and (d) of the code in that the operative procedure resulted in distortion and irregularity of the dorsal graft, nasal stenosis and airway obstruction.

(2) Respondent was grossly negligent, repeatedly negligent and engaged in acts of sexual misconduct with a

patient in violation of sections 2234 (b) and (c) and 726 of the code, in that during the course of the patient's office visits, respondent hugged the patient, invited her out, invited her to move in with him, and suggested she break up with her boyfriend. When the patient told respondent his asking her out wasn't ethical, respondent replied, "What's ethical?"

L.H.

F. On or about April 17, 1986, respondent undertook th care and treatment of L.H., a 35-year old female complaining of encapsuled breasts and seeking reduction of her chin size. On or about April 21, 1986, respondent performed surgery upo the patient.

(1) Respondent was grossly negligent, repeatedly negligent, and engaged in acts of sexual abuse and misconduct with the patient in violation of sections 2234 (b) and (c) and 726 of the code, in that during the course of the patient's office visits, respondent told the patient she had a beautiful body and turned him on and that he wanted to jump on top of her. Respondent told the patient she gave him a hard-on and asked her if she wanted to feel it. Respondent told the patient he had to wear his white coat because the patient gave him a hard-on. When examining the patient's breasts, respondent said he wanted to bite them. Respondent attempted to suck one of the patient's breasts. When examining the patient's chin, respondent stuck his tongue in the patient's ear and

started rubbing her breast. When the patient protested, respondent told her to be quiet because she could get him in trouble. Respondent told the patient she gave him a hard-on and that no one other than his wife made him feel that way. Respondent wanted the patient to give him a hug at the end of each visit.

B.D.

G. On or about April 3, 1986, respondent undertook the care and treatment of B.D., a 34-year old female seeking removal of a bump on her nose and the reduction of abdominal adipose tissue. On or about May 14, 1986, respondent performed a surgical procedure on the patient's nose and abdomen. On or about May 22, 1986, respondent again performed a surgical procedure on the patient's nose.

(1) Respondent's care and treatment of B.D. was grossly negligent, repeatedly negligent and incompetent in violation of sections 2234 (b), (c) and (d) of the code, in that:

(a) Respondent advised the patient to take aspirin pre-operatively.

(b) On or about May 22, 1986, respondent removed and replaced a proplast graft while the patient's nose was infected from the May 14, 1986, surgery.

(2) Respondent was grossly negligent, repeatedly negligent and engaged in acts of sexual abuse and misconduct with a patient in violation of sections 2234 (b) and (c) and 726 of the code, in that during the course of

the patient's office visits, respondent asked her if she could ever be in love with her surgeon and told her he "wanted to be a bad boy and jump on her."

(3) Respondent made and or signed false documents, and presented or caused to be presented a false or fraudulent insurance claim in violation of sections 2234(e), 2261, 2262 and 810(a) of the code, in that his operation report for the May 14, 1986, surgery which was submitted to the Connecticut General Life Insurance Company in support of an insurance claim, stated that the patient noticed and complained of an abdominal mass, which at times became painful, causing increasing disability, when in fact, the patient did not so notice or complain.

A.W.

H. On or about November 21, 1985, respondent undertook the care and treatment of A.W., a 26-year old female seeking breast augmentation surgery. On or about November 27, 1985, respondent performed said surgery. On or about December 4, 1985, January 15, 1986, and February 27, 1986, respondent performed additional surgeries in an attempt to correct the unsatisfactory results of the initial surgery.

(1) Respondent's care and treatment of A.W. was grossly negligent, repeatedly negligent and incompetent, in violation of sections 2234 (b), (c) and (d) of the code, in that the interval between surgeries was too short.

14. Respondent's certificate of licensure is further

subjected to discipline pursuant to section 2285 of the code, in that he has used the fictitious names "The Weissman Institute of Cosmetic Surgery" and "The Beverly Hills Institute of Cosmetic Surgery" in a public communication, advertisement, sign or announcement without having obtained a fictitious name permit pursuant to section 2415 of the code.

15. Respondent's certificate of licensure is further subject to discipline pursuant to sections 2271 and 651(g) of the code, in that he has engaged in false, fraudulent, deceptive and misleading advertising by advertising the availability of medical services he is neither trained nor qualified to perform.

WHEREFORE, complainant prays that a hearing be had and that following said hearing, a decision issue:

1. Suspending or revoking physician's and surgeon's certificate number A031649 heretofore issued to respondent;

2. Assessing a civil penalty of $500.00 for each violation of section 2262 of the code; and

3. Ordering such other and further relief as is just and proper.

DATED: February 4, 1988.

KENNETH J. WAGSTAFF
Executive Director
Board of Medical Quality Assurance
Department of Consumer Affairs
State of California

Complainant

STATEMENT OF

RICHARD. C. WEBSTER, M.D.,

ON BEHALF OF

THE AMERICAN BOARD OF COSMETIC SURGERY, THE AMERICAN ACADEMY OF COSMETIC SURGERY, AND THE AMERICAN SOCIETY OF LIPOSUCTION SURGERY.

BEFORE THE

HOUSE COMMITTEE ON SMALL BUSINESS

SUBCOMMITTEE ON REGULATION AND BUSINESS OPPORTUNITIES

APRIL 4, 1989

INTRODUCTION AND PRESENT PROBLEMS

All surgical specialties consist in part of varying cores of basic knowledge. These include 1) cardiopulmonary resuscitation, 2) medical care of the patient during and after surgery, 3) selection and use of anesthetic agents and techniques, 4) wound healing and scarring, 5) surgical infections, 6) control of bleeding, 7) diagnosis of the problems relating to the particular field, and 8) general aspects of diagnosis, care, and referral not just listed.

Every surgical specialty is made up of basic building blocks, the specific procedures listed in that specialty. Certain aspects of the core material apply to all surgical fields (such as cardiopulmonary resuscitation); certain portions vary depending upon the numbers and kinds of procedures included in the specialty. Obviously, it is not necessary for the specialist to know details of treating complications of intra-abdominal surgery if his specialty includes no intra-abdominal surgery.

Surgery consists of an enormous number of procedures. Depending on definitions, there are several hundred procedures in the more specialized field of plastic and reconstructive surgery (called "plastic surgery" by those who have their board certificates in that field); there are 150 - 200 specific operations in the specialty of facial plastic surgery; and, the entire specialty of cosmetic surgery is limited to between 40 and 60 procedures. Obviously, of these three specialties, cosmetic surgery is by far the most specialized and general plastic surgery the least.

In the evolution of specialties in America, it was once thought necessary to certify specialists in entire fields; but medical knowledge and surgical technology have expanded at enormous rates and fields are changing constantly. Certifying guidelines that were temporarily good enough to give some protection to the public 30 or 40 years ago have to be questioned today. This old system should be challenged even more strongly by those representing our citizens in helping evolve up-to-date mechanisms to protect the public from those with insufficient education, training, and experience in the actual procedures performed.

Each victim of an inadequately trained or inexperienced surgeon from whatever field recognized by organized medicine today is testimony to the failure of the present system to protect the consumer. Much good medical effort and brain power went into the preparation of this system, but all of the organizations and paraphernalia set up by organized medicine to continue the present Board system give no answer to the key question by the consumer about to have surgery. What the patient really needs to know is the answer to this question: "Is Doctor Smith, the specialist I have seen, adequately trained, sufficiently knowledgeable, and truly experienced in the particular operation I want to have performed?" Medicine's answer today, board certification in an entire field or discipline, does not and cannot answer that question.

Please let me use myself as proof of the weakness of the present mechanisms. I satisfied the requirements and passed the examinations necessary to become Board Certified in Plastic Surgery -- some 35 years ago. Not one operation, as I performed it during my last ten years in the much more specialized field of cosmetic surgery, did I learn during my required years enabling me to "get my Boards." Many of the procedures (liposuction, breast implants, etc.) had not even been invented. The actual techniques used in all the operations have changed totally or greatly with surgical progress. Every procedure done in my last ten years of practice was modified or learned from other practitioners at the postgraduate level (after the training permitting me to become board certified) or was evolved or developed by me after my original training, sufficient as it may have been then to allow me to become board certified.

Still, that board certificate permitted me, as an expert or a specialist in the entire field of plastic surgery, to get on the staffs of many hospitals and "entitled" me to be credentialed or to have privileges to do essentially every procedure listed in the huge fields of plastic and maxillofacial surgery -- limited only by my conscience and pride in doing well what I did do. Moreover, until I retired in 1987, I automatically was permitted to renew my privileges to do each and every procedure considered to be plastic or maxillofacial. Now, just because organized medicine endorsed the system that makes this series of events possible does not make the system right. In fact, it does not protect the public properly in today's increasingly sophisticated and competitive world.

I know, that despite a good mind and abundant energy, I cannot encompass the expanding knowledge required to be up-to-date and expert in every procedure making up the fields of plastic surgery, maxillofacial surgery, facial plastic surgery, or even the far more specialized field of cosmetic surgery. Further, I know, and those planning for the public good should know, that in spite of claims to the contrary, no one individual labeling himself an expert or a specialist in an entire field can have the volume of patients undergoing all of the procedures in that field to be expert in all.

The time has come for those elected to positions of responsibility to insist that those with vested interests in providing medical care come up with a better system. Some legal and social mechanisms for protection of the public are already in effect. Many of these mechanisms, however, require modification in order to be cost effective, socially just, and efficient, at the same time avoiding the stifling effects of overregulation. Nothing discussed here should be allowed to restrict healthy competition between those providing care. Further, nothing should be construed as suggesting the formation of a surgical or medical elite, the sole purpose of which would be to enhance the status of the providers without demonstrable improvement in the quality of care.

IMPROVING THE PRESENT SYSTEM

First, we must recognize that medical licensing laws are archaic. Laws permitting a license holder to do any and all things making up the practice of medicine and surgery must be changed. I believe that a new policy should be developed which would set certain basic requirements for the states to meet in licensing health care providers. Further, it may be necessary for modifications to state regulations in regard to malpractice. I believe federal antitrust statutes and regulations need to be enforced far more energetically in the medical, surgical and dental fields. Truth in advertising calls for more vigorous but appropriate limitations and enforcement. I could continue these suggestions at greater length, but time dictates that I concentrate on two fundamentals that must be emphasized here and that should be taken into account by responsible federal legislators.

One fundamental is that citizens in a society (ie: the consumer) must never relinquish their final say (through elected officials) in deciding just whom to license to provide them their health care. While many doctors genuinely believe, as I do, that they think always of the patient's good above their own, they do have a vested financial interest in providing that care. In spite of organized medicine's and dentistry's best efforts, there have been enough abuses to prove that never should final authority as to licensing be turned over to the providers. The rest of this first fundamental is that, once the consumers have decided who may be licensed, then the health care providers and their organizations should be encouraged or forced to set up mechanisms to continually educate to the fullest those licensed to do the job.

It is intolerable to allow organizations to decide entirely by themselves just which licensees they will permit to attend their educational events. Almost all of these organizations get sizeable tax benefits because, presumably, they are carrying out educational efforts accruing to the public good.

Most of us actually providing health care learned more about what we do after our early training years ended rather than during those years, though such training may have been sufficient to allow us certification in an entire field. Currently, there is great competition between organizations providing postgraduate medical teaching. Certain journals have repeatedly refused to publish advertisements or announcements listing the postgraduate medical activities of competing fields, organizations or individuals. These practices which restrict competition for the educational dollar must be prohibited.

The provider of health care must know what is being made available by all in order to appropriately select just which updating efforts will be best for him and his public. No organization with a journal nor any editorial board of a journal should be allowed to censor out or restrict the right of a competing field or group to inform readers of what educational events are available -- especially when that journal comes to the government for tax benefits. Individuals who are licensed should receive an unfettered and timely flow of knowledge, no matter which field or organization provides it.

CERTIFICATION - BY SPECIFIC PROCEDURE OR CLUSTER OF PROCEDURES; NOT BY AN ENTIRE FIELD.

The second fundamental is that all fields, or disciplines are made up of their building blocks, a limited number of specific procedures. In reality, however, there may be five or more fields training individuals to perform certain of these procedures. Inevitably, this overlapping results in competition between fields; competition that will surely continue.

For the future, then, it is imperative that those providing peer review or certification do it procedure by procedure or as close to that goal as practical and possible, rather than by giving approval for an entire field. We should provide that certification or peer reviewing be performed periodically rather than forcing the consumer to rely on some ancient evaluation. To repeat -- the applicant should be peer reviewed on the actual services that he provides, not on an entire field.

I have no great quarrel with board certifications per se, if these are relegated to their proper place in an entire scheme. But, organized health care providers have not kept up with the development of medical and dental specialties. If a practitioner in the field of plastic surgery limits his work to facial plastic surgery, he and the other approximately 3000 people specializing in facial plastic surgery should be allowed to call themselves facial plastic surgeons. Organized medicine should be prepared to recognize his specialty promptly and fully.

The same applies to the much more specialized field of cosmetic surgery. At this time, however, there are over 50 specialties waiting, in some case for years, for recognition by the American Board of Medical Specialties. Whether or not the delay in prompt recognition results from the vested interests of those in the limited number of specialties already recognized, I cannot say. But I can state that many practitioners in some of these waiting specialties now consider themselves to be competitively disadvantaged and restricted in describing to the public what they do.

One or two groups are currently seeking state legislation which would limit health care providers using yellow page listings, advertising, stationery and announcements, to only those specialty headings already recognized by organized medicine. This is like telling a small firm exclusively dealing with radon detection that they can only tell the public that they are Environmental Conservationists!

Obviously, the emergence of any new specialty is likely to be resisted by those who have competitively motivated desires to hold back the new and more specialized group. Even now, in certain states, though I specialize only in cosmetic surgery, I would not be able to advertise as such. I am required to either say that I am a plastic surgeon, (though I do none of the hundreds of plastic surgical procedures except for the small number of cosmetic operations) or where I am allowed to say that I am also board certified in cosmetic surgery, I must then add that my board certification in cosmetic surgery is not approved by organized medicine.

Of course it is not approved. And, as long as the organized plastic surgeons retain their present clout in organized medicine, the cosmetic surgical board will not get approval. I submit that cosmetic surgery is now a specialty and that the consuming public knows this to be true. Moreover, this entire Congressional hearing is about my field or specialty, that is, cosmetic surgery. It is not about facial plastic surgery, and not about the gigantic field of general plastic surgery.

Although I specialize, that is, limit my practice, more than most plastic surgeons, I am effectively denied any right to tell the consumer just that. This anticompetitive result of the present system provided by organized medicine and dentistry must be eliminated. The American Board of Medical Specialties (ABMS) should be encouraged to act promptly and without the stalling or foot-dragging effects of politically and economically motivated votes by specialties already recognized. If this is not possible, let me then suggest that another option would be to provide for accrediting mechanisms to compete with the ABMS. Only then, with official recognition of new specialties, can a level playing field be established in providing medical care.

ADDRESSING THE PROBLEMS

In regard to cosmetic surgery, organized medicine and dentistry have a long tradition of almost total indifference. They have been busy with what is considered by most to be "necessary" medical, surgical, and dental care. Cosmetic surgery which is devoted to perfecting the appearance of those already normal in appearance is considered "unnecessary" and elective in nature. It has been neglected so long that many of its practitioners decided to set up their own organizations; their own board, and even an accrediting commission to approve or disapprove of boards dealing with the cosmetic aspects of surgery, medicine and dentistry, as such boards emerged.

Today, the American Academy of Cosmetic Surgery is by far the largest organization in the world concentrating its educational endeavors entirely to the specialty of cosmetic surgery. These educational efforts are open to all licensed by the consumers to provide cosmetic surgical services. We have responsibility for the field, its practitioners, and for the consumers of cosmetic surgery. That is precisely why we are giving so much thought to the creation of mechanisms designed to improve cosmetic surgical care.

Consumers wanting these elective procedures need protection from the incompetent physician just as much as those requiring "necessary" care; in fact, probably more so. Marketing, not medical or dental necessity, can significantly increase the numbers of people seeking cosmetic care. Many of these procedures are performed in doctors' offices or "surgicenters" away from the protective eye of hospital peer reviewing and credentialing mechanisms. And because third parties wisely refuse to pay for most cosmetic care, the third party scrutiny tempering the unscrupulous practitioner is not present, as it is for non-elective and third-party covered care.

At first, the American Board of Cosmetic Surgery tested applicants on the entire field of cosmetic surgery, the core knowledge required in providing any and all of the 40 to 60 procedures making up the field, and selected details relating to any of the procedures, whether or not the applicant did all or just a few of the operations. To a certain extent, we did this because that was the way it was always done by the other boards set up for each of the recognized specialties. We eventually realized, however, that this approach did not really answer the consumer's key question mentioned earlier.

While no Board can certify that an individual is truly competent today in a given or specific procedure, our board, and the others before it, could certify that the applicant had shown to his peers at the time of the examinations evidence of sufficient training and education in the general aspects and the core knowledge of the particular field. Still, this alone, does not do the "real" job.

Most of our applicants already have their "Boards" in one of the earlier, broader, training disciplines. Yet, almost universally, they will testify that our examination - oral and written - is the most rigorous one that they have ever taken. Many have still not passed and remain uncertified in cosmetic surgery.

The leadership of the American Academy of Cosmetic Surgery and the American Society of Liposuction Surgery, as well as the trustees and advisors of our certifying board itself, felt that the time has come this year to become even more consumer oriented. They want to do what they can to zero in on the best answer they can give to the consumer asking the key question about a doctor's actual experience in a particular procedure.

As a result, in its next examination, our board will require the applicant to show that he is sufficiently trained and educated to meet his peer-decided requirements as to core and general knowledge and total volume of cosmetic operations performed in the past. Further, and most importantly, it will test for a much more detailed knowledge of the diagnostic and technical factors involved in the specific cosmetic procedures for which the applicant wishes to get peer certification.

This may require submission of a certain number of consecutive case reports dealing with that particular procedure or with small groups of related procedures. It will also require a sworn statement as to the numbers of those procedures that the individual has observed, performed as an assistant, performed under supervision, and then performed, particularly in a specified recent period, as an independent operator.

I want to call your attention to our emphasis on actual experience involving the number or volume of procedures. Fortunately, in the field of cosmetic surgery, the surgeon's volume of patients undergoing a particular procedure is more likely than in most other fields to have a relationship to competency. When it comes to improvement of appearance, the patients as well as prospective patients are often just as capable of judging the quality of the result as are the surgeons themselves.

In most other fields, the volume of procedures done by a surgeon is largely dependent on referrals to him by other doctors. In most cosmetic surgical practices, the patients come largely from other patients after they have seen the results of that particular procedure as performed by that particular surgeon. Advertising may modify this trend somewhat, but probably only for a relatively short time, since ultimately, patient dissatisfaction, malpractice, and problems in getting or paying malpractice insurance, would tend to limit the volume of those whose results are poor.

As one of the oldest living specialists in cosmetic surgery, I must admit to having a somewhat proprietary interest in this whole issue. However, wisdom and years of experience also have led me to the possibility that perhaps peer review mechanisms evolved by other organizations may help to answer the consumers questions as well as our board can. The American Board of Cosmetic Surgery has made great strides toward addressing the concerns about finding a qualified cosmetic surgeon, but we fully believe that others have much to contribute to this process as well.

With that in mind, we would urge that all the medical disciplines represented here today come together over the next year in order to work toward establishing minimal requirements for each of the cosmetic procedures. It is our hope that through today's hearing and with the future interest and support of you, Chairman Wyden, along with your colleages, we might be better able to facilitate such a cooperative arrangement that will ensure the quality of cosmetic surgical procedures for all consumers.

Finally, let me say on behalf of the American Academy of Cosmetic Surgery, the American Board of Cosmetic Surgery, and the American Society of Liposuction Surgery, that we are greatly encouraged to see this issue brought out into the open today. We commend you, Chairman Wyden, for acting as a catalyst in this critical debate, and we thank you for inviting us to testify before you today.

I will be happy to answer any questions you and your colleagues may have.

BRAUN
and Company

1112 16th Street, N.W.
Suite 210
Washington, DC 20036
(202) 785-1630

April 11, 1989

Mr. Frank Papineau
Professional Staff
Small Business Subcommittee on Regulation,
  Business Opportunities & Energy
B363 Rayburn House Office Building
Washington, D.C. 20515

Dear Frank:

In response to Mr. Wyden's request during last week's Subcommittee hearing on cosmetic surgery, attached is some additional information for the record provided by the American Academy of Cosmetic Surgery and the American Board of Cosmetic Surgery.

Specifically, the material contains information on the number of board-certified cosmetic surgeons who were "grandfathered" upon original incorporation of the Board of Cosmetic Surgery. In order to give you the basis for comparison, also listed is the same information in relation to the American Board of Plastic Surgery, as documented from two different publications.

In addition, we are enclosing the updated requirements for a candidate wishing to apply for certification by the American Board of Cosmetic Surgery. Finally, Dr. Webster has asked me to share with you the enclosed summary of statistics on lawsuits on file against board-certified plastic surgeons in Los Angeles County from 1979 through March 20, 1989.

If you have any questions about the enclosed materials, or if there is any additional information you need, please don't hesitate to give me a call.

Sincerely,

Cathy Imus

Catherine L. Imus
Braun & Company

Enclosures

AMERICAN BOARD OF COSMETIC SURGERY

REQUIREMENTS FOR CANDIDATE FOR CERTIFICATION BY

- The Candidate holds Board Certification in an original discipline approved by American Board of Medical Specialties.
- The Directors of the Board reserve the right to waive this requirement if, in its final judgement, the Candidate's training equals or exceeds that required for eligibility to take the Board Examinations in his original training discipline.
- Documentation that the clinical practice of the Candidate has been primarily in the field of cosmetic surgery for the most recent five years.
- The Candidate has performed at least 1,000 cosmetic surgical operations.
- The Candidate is currently performing at least 200 cosmetic surgical operations annually.
- The Candidate holds a valid medical license.
- The Candidate demonstrates the highest moral and ethical standards.
- Successful completion of American Board of Cosmetic Surgery Written and Oral Examinations. These are administered on an annual basis.

- A Candidate that has satisfactorily completed a ONE-YEAR APPROVED COSMETIC SURGERY FELLOWSHIP is eligible to take the written exam. The Candidate then must complete 500 cosmetic surgical procedures to be eligible for Oral Examination.
- A Candidate that has satisfactorily completed a TWO-YEAR APPROVED COSMETIC SURGICAL RESIDENCY is eligible to take the Written Examination. The Candidate then must complete 250 cosmetic surgical procedures to be eligible for Oral Examination.

QUALIFICATIONS FOR MEMBERSHIP
AMERICAN BOARD OF COSMETIC SURGERY, INC.

The qualifications for membership in the Board are that the applicant:

- certify that he or she has been practicing primarily in the field of cosmetic surgery for at least 5 years and has performed at least 1000 cosmetic operations;
- hold a valid medical license;
- demonstrate that he or she is currently performing at least 200 cosmetic procedures annually.
- If the applicant can document training in his or her original discipline that is equal to or greater than required to be eligible for Board Examination, then the Board of Directors may, at its discretion, waive the prior Board Certification requirement, accept the *Applicant as a Candidate for Examinations*, if all other categories of requirements are satisfied.
- A physician relying on completion of an approved fellowship must then complete 500 cosmetic procedures, and upon approval by the chairman of the board of examiners, will become eligible to take the written examination.
- A physician relying on completion of an approved residency must complete 250 cosmetic procedures, and upon approval by the chairman of the board of examiners, will become eligible to take the written examination.
- Once eligible for certification, to become certified the physician must pass both an oral and written examination. At the present time, approximately 60% of the applicants successfully complete the examinations.

If you meet the above requirements, please send your curriculum vitae together with a list of the operative procedures you have performed in the last calendar year. Please include where the surgeries were performed, in hospital (name) or office and the name of the patients. Send this to Richard B. Aronsohn, M.D., secretary of the American Board of Cosmetic Surgery, Inc., 159 East Live Oak Avenue, Suite 204, Arcadia, California 91006, telephone: (818) 447-1579. There is a $700 charge for processing your application. The $700 processing fee covers the written ($350) and oral ($350) examination fees. The balance of $300 will be due upon successful completion of the written and oral examinations. The total certification fee is $1000, which includes the examination fees (as stated above) and certification certificate. The Admissions Committee will review your qualifications and procedures and then make recommendations to the Board of Directors. You will be informed by mail of this determination.

The oral and written examination is given annually prior to The Annual Scientific Meeting of The American Academy of Cosmetic Surgery in Los Angeles, California.

The American Board of Cosmetic Surgery, Inc.

150 East Live Oak Avenue, #204
Arcadia, California 91006
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(914) [illegible]

Certification Examination Summary

1983 - 1989

Year	Number of Candidates	Number Certified	Percentage
1983	7	6	86%
1984	10	8	80%
1985	23	13	57%
1986	34	20	59%
1987	24	13	54%
1988	29	18	62%
1989	21	14	67%
TOTALS:	148	92	62%

The American Board of Cosmetic Surgery, Inc.

106 East Live Oak Avenue, #204
Arcadia, California 91006
(818) 447-1579

[illegible]

American Board of Cosmetic Surgery	American Board of Plastic Surgery *
The American Board of Cosmetic Surgery was incorporated in 1979.	The American Board of Plastic Surgery was founded in 1937.
The first Certification Examination was given in 1983.	The first Certification Examination was given in 1941.
Original Founding Members Certified with no required Examination — 134.	Original Founding Members Certified with no required Examination — 139.
Diplomates Certified by Examination (first 7 years) — 92.	Diplomates Certified by Examination (first 10 years) is approximately 150.
Average number Certified through Examination per year (first 7 years) — 13.	Average number Certified through Examination per year (first 10 years) — 15.

Source References

* Plastic & Reconstructive Surgery, Volume 82, Number 1, Pages 184 - 185, July, 1988, "The American Board of Plastic Surgery 1937 to 1987", Authors Clair C. Fox, Ph.D., William P. Graham, III, M.D.

Plastic & Reconstructive Surgery, Volume 68, Number 3, Pages 357 - 358, September, 1981, "The History of American Board of Plastic Surgery", Author Francis X. Paletta, M.D.

PLASTIC, AESTHETIC, AND COSMETIC SURGERY, P.C.

RICHARD C. WEBSTER, M.D.
16 PRESCOTT STREET
BROOKLINE
MASSACHUSETTS 02146

AREA CODE 617 566-2050

April 5, 1989

Braun & Company
ATTN: Cathy Imus
1112 16th Street, N.W.
Suite 210
Washington, D.C. 20036

Dear Cathy:

The following is the short version of the statistics read at the hearing:

This list is of the superior civil court cases from 1979 through March 20, 1989, from the Los Angeles County list. Eliminated from the listing taken from the 1989 directory of the American Society of Plastic and Reconstructive Surgeons (ASPRS) were 8 life members (probably retired) who still had 13 suits listed, and 30 candidate members who probably for the most part had had little time to develop many suits. Even so, 13 of these 30 had suits filed and one already had 6 suits. That left 138 active members. They had 436 suits, or over 3 each, listed. One had 23, another had 27. Five had 10 or more. Thirty three had 5 or more. Three of these plastic surgeons had critisized nonplastic surgeons on videotapes shown to the public on television programs. One of these had 1 suit, 1 had 5, and 1 had 11.

At least 3 of the suits involving these 138 members were for wrongful deaths. Besides being members of ASPRS, essentially all of these members board certified in plastic and reconstructive surgery.

Of the 138, 47 were also members of the American Society of Aesthetic Plastic Surgery (ASAPS), the general surgeons equivalent of a cosmetic surgical organization. Presumably, these would be the most expert group of their total numbers in the field of cosmetic surgery. However, they had 150 suits in the file or 3.2 suits each. Only 7 of the 47 who were members of ASAPS, ASPRS, and were board certified in plastic surgery had no suits. One of these had been president of the American Association of Cosmetic Surgeons, one of our societies that merged with another to form the American Academy of Cosemtic Surgery

We also have figures for San Diego County and Orange County. In the by and large they run very similarly to the findings of the Los Angeles County study.

Obviously, the plastic surgeons claiming that their board is supposed to give some special assurance of patient satisfaction have their problems too!

Best,

Richard C. Webster, M.D.

RW/eic

American
Academy of
Cosmetic
Surgery

President and Trustee

Richard T. Caleel, D.O., F.A.C.O.S.
20 E. Chestnut Street
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April 10, 1989

Mr. Ron Weyden, Chairman
Congress of the United States
House of Represenfatives
Committee on Small Business
2361 Rayburn House Office Building
Washington, DC 20515

Dear Congressman:

Enclosed please find a recent roster of our membership. Review of these figures will demonstrate that a minimum of 1,147 of our 1,520 have major surgical training. The majority of these individuals are board eligible or board certified in their original surgical specialties. In addition, 302 dermatologist are listed who have training in dermatologic surgical procedures. Also, many of these specialists have pursued their interest in cosmetic surgery and obtained additional training and experience in other cosmetic surgical procedures. Some of the other specialties included major surgical training however, the small number involved have not been included in the previously metioned figures. Futhermore, all of the members of our Academy do not perform the entire range of cosmetic surgical procedures. Indeed many individuals seek educational experience in our organization for a few selected topics.

I hope that this additional information will give greater insight into the activities of the majority of our membership. These facts refute many statments made by other panelist at the recent Congressional Hearing.

We thank you for your consideration and continued cooperation. Rest assured that we will do our utmost to cooperate with the committee in order to provide the best possible cosmetic surgical care to the public.

Sincerely,

Richard T. Caleel, D.O., F.A.C.O.S.
President

cc: Mr. Frank Papineau
Julius Newman, M.D.
Ms. Catherine L. Imus
Richard C. Webster, M.D.
Ms. Kimberly Davey

RTC:so

AMERICAN ACADEMY OF COSMETIC SURGERY - SPECIALTY BREAKDOWN
AS OF 3/24/89

	MEMBERSHIP STATUS					
SPECIALTY	FF	AM	RM	CM	EM/NM	TOTALS
Abdominal Surgery		2		1		3
Anaestehetic				2		2
Dentistry	1	1	1			3
Dermatology	149	101	26	20	6	302
Emergency Medicine	7	5	1			13
Endodermotology		1				1
Family Practice		6	1			7
F.I.C.S.				1		1
General Surgery	46	126	12	51	1	236
Hair Transplantation				1		1
Internal Medicine		2	1			3
Laser Surgery				1		1
Neurosurgery		1				1
Ob-Gyn	23	119	2	6	3	153
Ophthalmalogy	19	14	1		3	37
Oral/Maxillofacial	16	28	8	3	1	56
Otolaryngology/H & N	306	150	29	15	14	514
Pathology				1		1
Pediatrics	1					1
Phlebology		2				2
Plastic/Recon. Surg.	90	18	7	34	2	151
Preventative Medicine		1				1
Urology	1	1				2
Other/Unknown	5	2	1	4	16	28
TOTALS	664	580	90	140	46	1520

American
Academy of
Cosmetic
Surgery

President and Trustee

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PRESENTED BEFORE THE SUBCOMMITTEE
ON REGULATION, BUSINESS OPPORTUNITIES & ENERGY

COMMITTEE ON SMALL BUSINESS
U.S. HOUSE OF REPRESENTATIVES
APRIL 4, 1989

BY
RICHARD T. CALEEL, D.O.
PRESIDENT, THE AMERICAN ACADEMY OF COSMETIC SURGERY
PRESIDENT, THE AMERICAN SOCIETY OF LIPO-SUCTION SURGERY, INC.

Good morning, Mr. Chairman and members of the Subcommittee. My name is Dr. Richard T. Caleel. I am a cosmetic surgeon with an established practice in Chicago, Illinois. I am here today to speak to you in my capacity as President of the American Academy of Cosmetic Surgery and the American Society of Liposuction Surgery.

The mission of the American Academy of Cosmetic Surgery and the American Society of Liposuction Surgery is to provide an educational organization to serve the needs of health care professionals who have an interest in cosmetic surgical or dental procedures. These organizations are, first and foremost, for the purpose of education.

Through the Academy of Cosmetic Surgery and the Liposuction Society, World Congresses are sponsored, meetings and workshops are conducted, and publications are produced all to enhance our members knowledge of cosmetic surgical techniques and concepts. As officers of an educational organization, we open these meetings to all who are licensed to provide cosmetic surgical care. It is our firm belief that increased knowledge will benefit all of us and our patients, therefore, we make no attempt to limit access to our educational functions.

In order to further illustrate our commitment to the education of our membership, I think it may be helpful to first outline for you the goals of the Academy and the Liposuction Society as they currently exist:

1). The American Academy of Cosmetic Surgery and the American Society of Liposuction Surgery will maintain a multi-disciplinary educational organization open to all practitioners licensed to provide cosmetic surgical and dental procedures to the public;

2). The American Academy of Cosmetic Surgery and the American Society of Liposuction Surgery will assist in providing clinical and educational patient care environments that support the study, practice and research of cosmetic surgery at the highest quality level expected by the public;

3). The American Academy of Cosmetic Surgery and the American Society of Liposuction Surgery will continue to develop programs in health education and consumer information services that will improve the effectiveness of enhancing the health care of the public;

4). The American Academy of Cosmetic Surgery and the American Society of Liposuction Surgery will encourage an atmostphere of growth and support for the continuing medical education programs of their membership;

5). The American Academy of Cosmetic Surgery and the American Society of Liposuction Surgery will maintain a commitment to educational programs for allied health science professionals;

6). The American Academy of Cosmetic Surgery and the American Society of Liposuction Surgery will support the Accreditation Association for Ambulatory Health Care, Inc. and encourage our membership to utilize the services of that organization for accreditation of out-patient surgical facilities;

7). The American Academy of Cosmetic Surgery and the American Society of Liposuction Surgery will continue to encourage and support truth in advertising in order to protect the consumer;

8). The American Academy of Cosmetic Surgery and the American Society of Liposuction Surgery will continue to actively support the American Board of Cosmetic Surgery and its certification programs;

9). The American Academy of Cosmetic Surgery and the American Society of Liposuction Surgery will support and encourage the peer review programs of the American Board of Cosmetic Surgery and other appropriate organizations.

10). The American Academy of Cosmetic Surgery and the American Society of Liposuction Surgery will continue to solicit and encourage inter-organizational cooperation with related groups in order to foster the continued growth of our specialty for the benefit of its practitioners and for the consumer public.

Those of us in the American Academy of Cosmetic Surgery take great pride in the fact that the Accreditation Council for Continuing Medical Education granted accreditation of our organization for the maximum period allowed a new applicant following their first review of our programs. In addition, our publication, the American Journal of Cosmetic Surgery is enjoying continued growth and recognition for its contributions to the field of cosmetic surgery.

The Academy strongly supports "truth in advertising" by all physicians regardless of training, background or professional group affiliation. We object to any interference with the ability of an appropriately licensed physician to continue his medical education and to obtain appropriate hospital privileges and malpractice insurance coverage in order to practice. We support the American Medical Association's stand that privileges should be granted on the basis of training and experience and not certification.

The American Academy of Cosmetic Surgery and the American Society of Liposuction Surgery recognize that cosmetic surgery has become an art and specialty of its own. As the public demands higher aesthetic and technical standards for these services, the health care providers have pursued advanced training in their original areas of specialization.

We believe that no particular group of health care providers has a monopoly on the provision of these services nor is any group completely free of individuals who abuse them. We also believe that no group has a monopoly on education nor does any one group have the right to exclude other licensed professionals from obtaining a continuing medical educational experience.

At the Academy, it is our contention that one of the most effective weapons against unsatisfactory results is education. Since no single training discipline can adequately represent all those who have chosen to specialize in cosmetic surgery and dentistry, the American Academy of Cosmetic Surgery and the American Society of Liposuction Surgery act as a necessary and important voice for these providers. With that in mind, we shall continue to support the Cosmetic Surgery Information Service and its programs in cooperation with the American Board of Cosmetic Surgery in order to offer the public an appropriate avenue for information regarding cosmetic procedures and certified cosmetic surgeons.

Mr. Chairman, we appreciate your invitation to appear before the Subcommittee today to address the important issues surrounding the practice of cosmetic surgery. And on behalf of the Academy of Cosmetic Surgery and the Society of Liposuction Surgery, I would like to assure you and your colleagues in Congress that we stand ready to work together in a cooperative effort to see that the best possible cosmetic surgical care is available to the public.

I will be happy to answer any questions.

American
Academy of
Cosmetic
Surgery

General Offices

159 E. Live Oak Ave., Suite 204
Arcadia, CA 91006
818/447-1579
FAX: 818/447-7880

May 5, 1989

The Honorable Ron Wyden, Chairman
Subcommittee on Regulation, Business
  Opportunities and Energy
B-363 Rayburn HOB
Washington, D.C. 20515

Dear Chairman Wyden:

As President of the American Academy of Cosmetic Surgery, I would like to take this opportunity to offer some additional information on three issues related to cosmetic surgery which we believe were not adequately addressed during the April 4 hearing. Specifically, this letter will address recognition by the American Board of Medical Specialties (the ABMS), impediments faced by cosmetic surgeons in seeking hospital privileges, and the need for further investigation of the industry by the Federal Trade Commission.

During testimony at the April 4 hearing, representatives of the American Board of Plastic and Reconstructive Surgery (ABPRS) repeatedly touted recognition by the American Board of Medical Specialties (ABMS) as proof of legitimacy in the field of cosmetic surgery, in contrast to all other boards which do not enjoy similar ABMS recognition. In testimony as well as in advertising by its' members, the ABPRS implies that because it is the only board recognized by the ABMS, the public should consider only its' surgeons qualified to perform cosmetic surgery.

Currently, there are over 50 specialties awaiting recognition by the American Board of Medical Specialties. The last new specialty added to the list of ABMS approved boards was emergency medicine in 1979, ten years ago. I should also point out that it took the American Board of Plastic and Reconstructive Surgery ten years to gain ABMS recognition. The process involving recognition is slow and arduous at best, and as such, should not be given undo significance in determining which boards are better than others, regardless of the specialty involved. Further, the American Board of Cosmetic Surgery is, again, one of many hoping to obtain ABMS recognition - that it has not yet done so is in no way indicative of its quality or the quality of its' surgeons.

Among the ABMS requirements for recognition of a specialty board is "satisfactory evidence that the proposed board is the only one in the specialty having broad professional support, and that approval will promote and enhance recognition of a single standard of preparation for practice in each specialty." Certainly, with a membership of more than 1,200, the American Academy of Cosmetic Surgery enjoys broad support, as does the Board of Cosmetic Surgery with its 300-plus certified surgeons.

Further, given the evolving nature of highly specialized cosmetic procedures, many of which have only been in existence for the past ten years, there is no single training program capable of providing totally adequate preparation, including that of the Board of Plastic and Reconstructive Surgery. Likewise, with the resulting controversy surrounding qualifications of surgeons performing cosmetic procedures, this requirement alone should suggest a very real need for recognition of cosmetic surgery as a separate specialty with a separate certifying board. Only then can "recognition of a single standard of preparation for practice" be established and upheld.

However, according to the stated policy of the ABMS, we have little real chance for such recognition because cosmetic surgery is still considered within the realm of general plastic and reconstructive surgery. According to the March 1983 version of "Essentials for Approval of Examining Boards in Medical Specialties", put out by the ABMS, "...only one certifying board will be recognized in each specialty."

In addition to policy obstacles, the very attitude of ABMS officers suggests serious difficulties with the recognition process for specialty boards by ABMS. Recently, the Executive Vice President of the ABMS, Donald G. Langsley, M.D., gave clear indication of the prevailing attitude of the ABMS in recognizing new specialties when he described the application process as "...lengthy and difficult" with today's applicants facing "...political obstacles." Obviously, the decision to apply for ABMS recognition cannot be taken lightly given the negative outlook for approval.

In light of ABMS policy and the attending attitude, non-plastic surgeons who wish to practice cosmetic surgery are effectively prevented from attaining board certification from any ABMS recognized board -- unless, of course, they wish to go through a residency in plastic and reconstructive surgery to become eligible for certification by the American Board of Plastic and Reconstructive Surgery. In other words, if he wishes to get ABMS-recognized board certification to practice the 40 - 60 specific cosmetic procedures that exist, a surgeon must complete a residency covering the 400 - 600 procedures under plastic and reconstructive surgery.

Since this alternative is impractical for most surgeons, who already hold certification in their original fields, the ABMS policy has effectively secured the practice of cosmetic surgery for one specialty to the exclusion of all others.

It would seem, then, that the overriding interest of the American Board of Medical Specialties is to protect the "turf" of its existing specialty boards, rather than to protect the consumer. Clearly, the ABMS' decision to recognize only one board for the practice of cosmetic surgery perpetuates the monopolistic attitude of plastic surgeons thereby arbitrarily restricting competition to the ultimate detriment of the consumer.

Further, recognition by the ABMS does not guarantee the competence of a given surgeon in any field. Board certification by traditional ABMS recognized Boards merely indicates that a candidate had accrued academic knowledge of core curriculum offered during a residency -- in reality, board certification may have little relevance to a surgeon's actual practice.

In the case of Plastic and Reconstructive Surgery, for example, neither that field's residency program nor Board exams, can devote more than a relatively small percentage of time to cosmetic surgery, given the hundreds of other plastic and reconstructive procedures covered within the field. None of the Boards currently recognized by the ABMS can fully certify a physician in the growing field of cosmetic surgery, because these Boards have other testing responsibilities for the broad field by which each is named.

The American Board of Cosmetic Surgery is the first board to take steps toward providing the public with the actual information that it is seeking - namely, whether or not an individual surgeon has current knowledge in a specific area of concern. The new ABCS requirements for certification (see attachment) are among the toughest in medicine today. We would be happy to submit an application to the ABMS for recognition if we can be assured that the aforementioned policy of recognizing only one entity per field has been changed.

The second issue to be addressed focuses on hospital privileges for cosmetic surgeons. As you are aware, there are efforts underway in various state legislatures to restrict the practice of cosmetic surgery to only those surgeons holding hospital privileges. Unfortunately, obtaining hospital privileges is not an easy task for non-plastic surgeons, and in some instances, it has been virtually impossible.

In 1984, the House of Delegates of the American Medical Association adopted a policy regarding criteria for delineating clinical privileges which stated that "delineation of privileges shall be determined on an individual basis, commensurate with an applicant's education, training, experience and demonstrated current competence." The American Board of Medical Specialties has also stated that specialty training is only one of several valid and important criteria for granting hospital privileges.

Yet, in many instances when non-plastic surgeons have sought hospital privileges for cosmetic procedures, they have been rejected despite years of experience, extensive training and exceptional competence. In reality, the determining factor is rejecting these surgeons has not been related to skill, but rather to politics.

American hospitals are entrenched in an "old boy" medical political system of credentialling, in which certain individuals or groups within a given hospital have tremendous power to exclude or control who does or does not get hospital privileges to do certain procedures. In a report issued on April 5, 1989, titled "Physician Discipline in California: A Code Blue Emergency", author Robert C. Fellmeth of the Center for Public Interest Law at the University of San Diego addresses the political pressure involved in decisions on such things as hospital privileges and physician discipline. He cites the private decision making of medical clinics, hospitals and other institutions as contributing to serious problems.

> "Physicians must have access to these facilities in order to practice, and to the extent that these facilities deny that access, they affect who the practitioners are. The extent to which a group of competitors controlling a medical facility is able to effectively boycott a competitor by excluding him/her from an institution may indicate incentives other than the objective evaluation of medical performance. In an industry as lucrative as medical practice, such ancillary incentives are not insignificant."

To illustrate this point, enclosed is specific documentation regarding one example of denial of privileges for a cosmetic surgeon whose past experience and current competence more than adequately satisfied the requirements described above; yet who was nonetheless denied.

In addition to political efforts to deny hospital privileges to cosmetic surgeons, the plastic surgeons have sought other more practical means for eliminating their competition. One method has been to make it more difficult for cosmetic surgeons to obtain reasonable malpractice insurance, without which they cannot be granted hospital privileges. We are aware, for example, of one prominent member of the American Society for Plastic and Reconstructive Surgery who also sits on the Board of one of the nation's largest malpractice insurance companies. This individual, along with several board members who are plastic surgeons, has gone to great lengths to discourage this company from issuing malpractice insurance to non-plastic surgeons.

Further, despite claims to the contrary by plastic surgeons, there are valid reasons why 95% of cosmetic procedures are done in office facilities, whether by non-plastic surgeons or plastic surgeons, and they revolve around availability and cost. For elective procedures such as cosmetic surgery, scheduling of hospital surgical facilities is often difficult since, logically, non-elective or "necessary" surgery takes priority. Secondly, the cost factor in utilizing hospital facilities often makes the procedure cost-prohibitive to the patient.

Certainly, regardless of location for any procedure, we strongly believe in a mechanism for ensuring the highest quality in surgical facilities. Again, that is precisely why the American Board of Cosmetic Surgery, in developing the most comprehensive criteria for certification of its members, has instituted the first peer-review program for inspecting out-patient facilities.

Under the ABCS peer-review program, if the doctor's surgery is entirely office based, with no hospital affiliation, the doctor will have to, prior to his acceptance to take the examination, submit to intense scrutiny by two certified cosmetic surgeons. They will evaluate the applicant's facility, observe his surgery, review record keeping, and evaluate the entire operation of the facility.

In addition, the Board of Cosmetic Surgery strongly encourages that office-based surgical facilities be accredited by an organization such as the Accreditation Association for Ambulatory Health Care (AAAHC). We agree that many office-based facilities are not adequate -- including cosmetic surgeons, plastic and reconstructive surgeons, and others. As such, we also fully support efforts to establish a national program for instituting guidelines and standards for office based surgical facilities, another function which could be addressed with the establishment of a seperate ABMS board for cosmetic surgery.

The American Academy of Cosmetic Surgery fully supports the active involvement of the federal government to sort out the conflicting information surrounding cosmetic surgery. In order to facilitate the most comprehensive and unbiased investigation, we believe it is imperative that the Federal Trade Commission reopen their earlier restraint of trade case involving plastic and cosmetic surgery. Only then can the American public as well as the various medical disciplines involved in the dispute be assured that the highest standards of competency, training and experience are being met in all fields practicing cosmetic surgery.

Again, Mr. Chairman, we applaud your efforts to investigate many of the issues affecting the practice of cosmetic surgery, and we welcome the opportunity to work with you and your staff in the coming months to develop appropriate guidelines and standards for the practice of cosmetic surgery. The AACS also believes, however, that the complexities of the situation warrant a more detailed study such as can only be accomplished adequately with the full resources at the disposal of the Federal government through the Federal Trade Commission.

With that in mind, we would encourage you and your colleagues on the Subcommittee on Regulation, Business Opportunities and Energy to request that the Federal Trade Commission begin an immediate investigation into the field of plastic and cosmetic surgery.

Thank you for your attention to this important matter. If you or your staff have any questions about the information contained in this letter or its' attachments, please do not hesitate to contact the American Academy of Cosmetic Surgery, either through me directly or through our Washington representative.

Sincerely,

Dr. Richard T. Caleel
President, American Academy
of Cosmetic Surgery

Enclosures

cc: Rep. William Broomfield
Frank Papineau, Subcommittee staff

CANDIDATE REQUIREMENTS
FOR
CERTIFICATION
AND
SUBCERTIFICATION
BY
THE AMERICAN BOARD OF COSMETIC SURGERY

I. Candidates should have board certification in any one of the following specialties (Cosmetic Surgery fellows and residents must have board eligibility in their primary specialty): General Surgery
Otolaryngology/Head & Neck
Plastic & Reconstructive
Gynecology
Orthopedics
Dermatology
Maxillo Facial Surgery with Dual M.D./D.D.S. Degrees

Areas of subcertification:

1) Cosmetic Surgery
2) Facial Cosmetic Surgery
3) Body & Extremity Cosmetic Surgery
4) Facial Liposuction Surgery
5) Body & Extremity Liposuction Surgery
6) Dermatologic Cosmetic Surgery
7) Cosmetic Breast Surgery
8) Ophthalmic Cosmetic Surgery
9) Cosmetic Laser Surgery

Those requesting board certification and subcertification in the field of cosmetic surgery must pass their oral examination in Categories 1 through 9. You may choose any one from the above list according to your training qualifications.

For doctors using various areas of subcertification, each area of subcertification must include a minimum of 50 cases in each particular area.

The candidate must have completed a minimum of 300 cosmetic surgical procedures in the full year prior to their application and have been performing surgery in his particular designated area of expertise for the past five years and has completed at least 1000 cosmetic surgical procedures.

For doctors who have already received subcertification certificates who wish to return for subcertification in a new area, must submit 50 surgical procedures within the past year, including pre and post operative photographs and case history. The candidate must also include letter of recommendation from facilities they have trained with in that particular area.

All Candidates will take the same written examination. The oral examination will be given in the area of the chosen subcertification category. Each individual taking the oral examination will be expected to have a general knowledge of cosmetic surgical procedures outside of their particular area of subcertification.

II. One Year Approved Cosmetic Surgical Fellowship.
The Candidate may take his written examination upon completion of his training program. He must complete at least 500 cosmetic surgical procedures as the primary surgeon with no time restraints to be eligible for the oral examination.

III. Two Year Approved Cosmetic Surgical Residency.
The Candidate may take his written examination upon completion of his training program. He Candidate must complete 250 cosmetic surgical procedures as the primary surgeon with no time restraints to be eligible for the oral examination.

If you meet the above requirements, a written request for the Board examination application should be directed to the American Board of Cosmetic Surgery, Inc., 159 East Live Oak Avenue, Suite 204, Arcadia CA 91006, telephone: 818-447-1870.

There is a $800.00 charge for processing your application. It covers both the written ($400) and oral ($400) examination fees. Upon successful completion of both the written and oral examinations there will be a $350.00 charge for your certificate. Surgeons returning for recertification in a new area, the fee is $450.

The oral and written examination is given annually prior to the Annual Scientific Meeting of the American Academy of Cosmetic Surgery in Los Angeles, California.

In October of each year there will be a cosmetic surgery board review course held at the Airport Hilton Hotel, Chicago IL. This is a two day intensive program for board preparation. The fee is $500.00.

For Candidates who do not have any hospital operating room privileges and perform all their surgical procedures in their office, will be required to have an on-sight visit by a team of cosmetic surgeons to evaluate their surgical facility, live surgical cases, and an examination of patient records. The cost of this will be paid by the Candidate.

Candidates must submit letters of recommendation from the Chairmen of their Residency Training Program and from their Departmental Chief at their current hospital facility.

DR. SHIPPERTS SUMMARY
OF EVENTS TO PRESENT

Ronald D. Shippert, M.D., P.C.

6099 South Quebec, Suite #200

Englewood, Colorado 80111

Dr. Richard Webster
16 Prescott St.
Brookline, Ma 02146

March 1, 1989

Dear Richard,

As you are aware in May of 1987 I applied for additional privileges at Human Hospital in Aurora, Colorado in the area of body Liposuction and Breast Augmentation.

In accordance with the hospital bylaws I appeared before the credentials committee to present my request, and in spite of giving them adequate proof of additional training and experience in these procedures the requests were denied. The recommendation for denial was done by an appointed group within the surgical department that consisted of several Plastic Surgeons. The basis for denial was that I had not completed a residency in Plastic Surgery and that my former training was in Otolaryngology. From here this went to the Executive Committee for approval and again the request was denied.

The next step in the bylaws was to have a hearing by five other staff physicians. On this committee there was only one Plastic Surgeon. IN THIS CASE MY REQUESTS WERE UNANIMOUSLY APPROVED AND A RECOMMENDATION WAS SENT BACK TO THE EXECUTIVE COMMITTEE TO APPROVE MY REQUEST FOR BREAST AUGMENTATION AND BODY LIPOSUCTION. HOWEVER, WHEN THIS RECOMMENDATION WAS RETURNED TO THE EXECUTIVE COMMITTEE IT WAS REFUSED AGAIN AND IN ADDITION THEY RECOMMENDED THAT MY PRESENT OTOLARYNGOLOGY PRIVILEGES NOT BE RENEWED FOR THE COMING YEAR.

I have enclosed also a letter from the head of the Surgery Department at Humana that was sent to me in April of 1988 indicating that I was in good standing for my

Otolaryngology privileges.

Now I am caught in a "catch 22" situation, where if I pursue my requests for additional Breast and Liposuction privileges, I will not have my Otolaryngology privileges renewed. In addition to this, I was told by Mr Atkinson, the Superintendent of the hospital, that should this happen, it must be reported to the State Board of Medical Lisensure, which at best would not be good on my record, and at its worst, could endanger my medical lisensure. For this reason I am reluctantly considering a formal resignation, to prevent such possibilities.

It is my opinion that the Executive Committee and Credentials Committee have not acted in the interest of the patients, but have acted with vested economic interests. I feel that their decision to deny me privileges was unreasonable, capricious, and arbitary.

You are well aware of my experience and training in breast augmentation and body liposuction, and are fully aware that my experience level exceeds that of the average Plastic Surgeon just out of his residency, WHO IS AUTOMATICALLY AWARDED THESE SAME PRIVILEGES.

I am giving this information to you to add to your collection of similar cases. Something must be done to prevent this restriction of trade by one specialty group. I understand that you will be soon talking to a Federal Agency about these problems, so feel free to use this as a typical case.

Please keep in touch.

Sincerely,

Ron Shippert

Ron Shippert M.D.

ATTORNEY ALPERSTEINS
SUMMARY OF EVENTS TO
PRESENT

ALPERSTEIN & COVELL, P.C.

ATTORNEYS AT LAW

1890 GAYLORD, DENVER, COLORADO 80206-1211
(303) 355-1890

March 9, 1989

Dr. Richard Webster, M.D.
16 Prescott Street
Brookline, MA 02146

Dear Dr. Webster:

Our client, Dr. Ronald D. Shippert, has asked that I write to you to explain some of the legal considerations attendant upon handling of his request for certain augmented privileges at Humana Hospital-Aurora.

For several years, Dr. Shippert has had complete head and neck surgery privileges at Humana Hospital Aurora. In 1987, he informed the hospital of his desire to seek an extension of privileges to include body liposuction (facial liposuction privileges having already been granted) and breast augmentation surgery. Complete applications covering both requests were submitted to the hospital in May, 1988. In July, the Surgery Department Credentials Committee recommended denial of both requests, and the Medical Executive Committee, apparently, ratified that recommendation the same day it was made. However, Dr. Shippert was not notified of the Medical Executive Committee decision until November, 1988.

Dr. Shippert thereafter requested and received a hearing before an ad hoc committee of the Medical Staff, as provided by the Hospital's bylaws. That hearing was held on January 19, 1989, and was reported by a Certified Shorthand Reporter. The committee unanimously approved both applications, and passed its report on to the Medical Executive Committee. Astoundingly, the Executive Committee, on February 14, 1989, rejected the Hearing Panel's recommendation, and did so on grounds totally unrelated to any previously enunciated rationale for questioning Dr. Shippert's qualifications. Then, in what I can only characterize as an astonishing act of retaliatory vindictiveness, and without notice or any other attention to procedural safeguards, the Executive Committee voted to withdraw all of Dr. Shippert's existing privileges.

From the outset, I have been concerned about four key legal principles which have been consistently violated by the Hospital and its staff.

DONALD W. ALPERSTEIN   CYNTHIA F. COVELL

ATTORNEYS OF COUNSEL
HERBERT L. STERN, III   RONALD C. FORMAN

First, there has been an abject failure of the Medical Staff to abide by its own internal rules as embodied by the Bylaws and Rules and Regulations. The situation has improved somewhat since the Hospital became aware of my involvement in October, 1988. Prior to that time, the staff engaged in such flagrant abuses as failing to notify Dr. Shippert of official actions on his requests, withholding from him the reasons for administrative decisions effecting his status and refusing to provide him with copies of applicable rules and regulations. Such nonchalant inattentiveness to establish procedures is an insult to any notion of fair play or due process.

The Medical Staff's enunciated reasons for rejecting Dr. Shippert's requests have been inconsistent and irrational. Moreover, it is my professional opinion that certain of the applied standards are violative of Colorado statutory law. For example, board certified plastic surgeons are automatically granted the privileges which Dr. Shippert seeks, and they are not required to demonstrate knowledge, training or experience in the procedures before they are allowed to perform them at Humana Hospital-Aurora. However, no amount of knowledge, training or experience is recognized as adequate in the absence of board certification in plastic surgery. In effect, then, board certification is the sole criteria by which such requests will be granted. However, Colorado statutes provide that privileges must be granted, without discrimination as to medical specialty, when competence is established and so long as the procedure is within the ambit of the practitioner's licensure.

Related to this disregard of statutory law is the Medical Executive Committee's practice of changing its enunciated grounds for denial of Dr. Shippert's requests. Initially, the Executive Committee stated two reasons for denying his petitions:

> "The documentation and training which you provided is not from a program recognized by the American Board of Medical Specialties and the American Medical Association" and
>
> "The Department felt that you did not have the residency training to be doing these procedures and could not deal with the full range of diagnostic possibilities and potential complications."

At his hearing before the ad hoc committee, Dr. Shippert addressed these issues by noting that ABMS accreditation had been extended to the CME courses in question, and by advising the Committee of the Colorado statute prohibiting discrimination based on areas of specialization, noted above. Dr. Shippert apparently satisfied the staff's concerns, for the ad hoc committee unanimously voted to recommend that he be granted the requested privileges. When the matter again came before the Medical Executive Committee, they once more rejected his request, this time on the new ground that Dr. Shippert's:

> "... main area of expertise was not sufficient to perform the requested procedures and the procedures have been performed in his office; this is not equivalent to hospital procedures which are monitored by quality assurance activities with cases evaluated."

In other words, having once told Dr. Shippert why his requests were rejected, and Dr. Shippert having answered those concerns, the Medical Executive Committee trumped up an entirely new set of criteria and reasons for denial. Either they failed to provide him notice of the grounds for their initial decision (assuming the most recently enunciated reason was not mere afterthought) or they have concocted up after-the-fact rationalizations for bringing about a result with no regard to procedural requirements, due process, or basic fairness.

Finally, and as further evidence of a result-oriented attitude, as opposed to any inclination toward rational decision making, the Medical Executive Committee, at that same February 14 meeting, voted to deny Dr. Shippert's pending request for renewal of his existing and longstanding privileges. That action can only be characterized as punitive, vindictive and retaliatory. The move was clearly designed to punish Dr. Shippert for having sought augmented privileges and was obviously intended to dissuade him, and others, from seeking entry into the "club" of those who will be approved to perform the procedures in question. Economics, not legitimate medical concerns, are motivating the actions of the Medical Executive Committee, thus raising concerns about trade restraints and attempts by one group of doctors to monopolize a lucrative area of practice.

I hope you will find the foregoing analysis of some use. Dr. Shippert has asked that I cooperate with you fully, and if there is any additional information I can provide, or if I can be of further assistance, please feel free to call upon me.

Very truly yours,

Donald W. Alperstein

DWA/mre
cc: Dr. Ronald D. Shippert, M.D.

American Academy of Cosmetic Surgery

American Academy of Cosmetic Surgery

Introduction

The American Academy of Cosmetic Surgery is the only organization established to represent all health care professionals who specialize in cosmetic surgery or dental image enhancement procedures. The Academy is a multidisciplinary group open to all physicians, dentists, or practitioners licensed to provide surgical, medical, or dental services to the public.

As the public demands higher aesthetic and technical standards of cosmetic surgery and cosmetic dentistry, they have become arts and specialties all their own. The physicians and dentists providing these services have pursued advanced training, following training in their original areas of specialization. It is clear that no particular group of surgeons has a monopoly on good results, skill, or experience.

The AACS Goals

The American Academy of Cosmetic Surgery is, first and foremost, a teaching organization. We have been fortunate in attracting superb teachers to our ranks. In order to enhance its members knowledge of cosmetic surgical techniques and concepts, the AACS sponsors World Congresses, meetings, workshops, residencies, fellowships, and publications. As a scientific organization, we open these avenues to all who are licensed to provide cosmetic surgical care. We do not believe in limiting access to education which will benefit both physician and patient.

The American Academy of Cosmetic Surgery serves the needs of the professions of cosmetic surgery and cosmetic dentistry and provides the public with information about related treatments. The AACS welcomes the membership of all qualified professionals interested in advancement of the field.

Benefits of Membership

- Annual Scientific Meetings and Workshops.
- International congresses featuring discussion of the newest and most advanced techniques in our field.
- Observational Teaching Program.
- Subscription to the American Journal of Cosmetic Surgery.
- Toll-free Public Service Line offering the public information on cosmetic surgery and referrals to subscribing members.
- Subscription to the quarterly newsletter "Cosmetic Surgery Newsline" providing information on current events, seminars, legislative information, and membership updates.
- Access to the AACS Educational Foundation and the Cosmetic Surgery Library and Museum.

The American Society of Lipo-Suction Surgery

The American Society of Lipo-Suction Surgery is affiliated with the American Academy of Cosmetic Surgery. Its goals are:

- To educate, inform, and advance its members in the specialty of lipo-suction surgery.
- To promote the highest standard of excellence in lipo-suction surgical care.
- To encourage the free exchange of ideas and techniques between its members.

Benefits of the American Society of Lipo-Suction Surgery:

- Invited participation in AACS World Congresses, Annual Scientific Meetings, and seminars.
- Three-day Lipo-Suction Workshops.
- A network of communication throughout the United States of cosmetic surgery assistants.

Open to the following specialties:

- Otolaryngology/head and neck surgery.
- Plastic and reconstructive surgery.
- Dermatologic surgery
- General surgery.
- Gynecologic surgery.
- Orthopedic surgery.
- Cosmetic surgery.
- Oral and maxillofacial surgery.

The Cosmetic Surgical Para-Medical Affiliates

The Cosmetic Surgical Para-Medical Affiliates is a section of the American Academy of Cosmetic Surgery. Its goals are as follows:

- To educate, inform, and advance cosmetic surgery specialists who have been trained by or work with the offices of AACS and/or ASLS surgeons.
- To encourage general interest, cooperation, and participation between its members and the members of the AACS and/or ASLS.
- To promote public interest, cooperation, and confidence in the integrity and expertise of qualified Cosmetic Surgical Para-Medical Affiliates.

Benefits of the Cosmetic Surgical Para-Medical Affiliates

- Cosmetic Surgical Para-Medical Affiliates Seminar held in conjunction with the Annual Scientific Meeting.
- A network of communication throughout the United States of cosmetic surgery assistants.

Categories of Membership

Full Fellow
Full voting rights. Documented proof of at least 100 cosmetic procedures performed in the 12 months ending with the date of application must be submitted. Applicant must be Board Certified or Board Eligible in their stated specialty and must be approved by the Credentials Board.

Corresponding Member
International exclusive of U.S. and Canada. No procedure list required. No vote. Membership services provided.

Associate Member
No procedure list required. No vote. Membership services provided. After three years in this status, dues will be the same as for a Full Fellow.

Fellow or Resident Member
No procedure list required. No vote. Membership services provided. At the beginning of the year after your residency or fellowship training ends, you must apply for one of the three categories above.

American Academy of Cosmetic Surgery Membership Application

Submit the appropriate non-refundable fee along with the completed application, curriculum vitae, and a recent photo to:

The American Academy of Cosmetic Surgery
159 E. Live Oak Ave., Suite 204
Arcadia, CA 91006
818-447-1579

Name______________________________ Degree__________
Business Address____________________________________
City, State, ZIP______________________________________
Business Phone(______)_____________________________

Home Address______________________________________
City, State, ZIP______________________________________
Home Phone(______)_______________________________

License: ☐ Medical ☐ Dental - Number__________________
State or Country______________ Date obtained______________
Is it in effect and unqualified? ☐ Yes ☐ No
If no, explain. (Use separate sheet if necessary.)______________
____

Board certified or eligible? ☐ Yes ☐ No
If yes, which Board?______________________________
Date certified____________________________________
If no, which field did you train in?_____________________

Active membership in:

☐ AMA ☐ ADA ☐ ACS or equivelant
☐ AOA ☐ ASLS

Your original training discipline's main organization:
____

Upon application for Full Fellowship applicant must enclose documentation of the required 100 procedures. Also, residents must include a letter of verification from preceptor of current residency program.

I agree that membership in the American Academy of Cosmetic Surgery is a privilege not a right. I recognize that the contents of this application will be seen by individuals working in and for the AACS. I agree to return my certificate of membership if my license to provide cosmetic surgery is revoked, suspended, or limited beyond its present state, or if membership is revoked for such other cause as may be placed legally in the bylaws of the Academy.

Signature ______________________________ Date__________

American Society of Lipo-Suction Surgery
Membership Application

Submit the appropriate non-refundable fee along with the completed application and curriculum vitae to:

The American Society of Lipo-Suction Surgery
159 E. Live Oak Ave., Suite 204
Arcadia, CA 91006
818-447-1579

Name______________________________ Specialty________
Address____
City, State, ZIP____________________________________
Phone(______)____________________________________

Board certified or eligible? ☐ Yes ☐ No
If yes, which Board?________________________________
If no, which field did you train in?________________________

Active membership in:

☐ AMA ☐ ADA ☐ ACS or equivelant
☐ AOA ☐ AACS

Your original training discipline's main organization:

____

Accredited lipo-suction workshop(s) attended:

____
____
____

Signature ______________________________ Date__________

Cosmetic Surgical Para-Medical Affiliates Membership Application

Submit the appropriate non-refundable fee to:

The American Academy of Cosmetic Surgery
159 E. Live Oak Ave., Suite 204
Arcadia, CA 91006
818-447-1579

Name____________________________________ Degree____________
Address____
City, State, ZIP____
Phone(______)____

Sponsoring physican____

Sponsoring physican has active membership in:

☐ AMA ☐ ADA ☐ ACS or equivelant
☐ AOA ☐ AACS ☐ ASLS

Sponsoring physican's original training discipline's main organization.____

Please list your current responsibilities:________________________
____
____

Sponsor's signature ____________________________ Date_________

Applicant's signature __________________________ Date_________

PRESENTED BEFORE THE SUBCOMMITTEE ON REGULATION, BUSINESS OPPORTUNITIES & ENERGY

COMMITTEE ON SMALL BUSINESS
U. S. HOUSE OF REPRESENTATIVES
APRIL 4, 1989

BY
JULIUS NEWMAN, M.D.
PRESIDENT, AMERICAN BOARD OF COSMETIC SURGERY

In 1979, a group of cosmetic surgeons decided there was the need for a new specialty, namely, cosmetic surgery. It was our goal to have this new specialty involve surgeons from various surgical specialties. After three (3) years, of endless hours spent by many dedicated surgeons, the first Board examination was able to be administered. The first group of doctors sat for this examination in Los Angeles, California, in January of 1982.

Because this new specialty, cosmetic surgery, was so complex, and because there were many new cosmetic surgical procedures, along with there being an unexpected high demand by the general public for cosmetic surgery, our group was convinced that this specialty had to be established as a separate discipline.

The plastic and reconstructive surgeons, on the other hand, publicly took the stand that the cosmetic surgical training given in their two (2) year residency program was sufficient. They further stated that they did not see the need for a separate specialty. But, in 1982, three (3) well-known and respected plastic and reconstructive surgeons incorporated their own Board of cosmetic plastic surgery. Their incorporation papers are attached as Exhibit "A". Not knowing that our organization had been incorporated in another state, and was already functioning in the State of California, they contacted the District Attorney's Office in Los Angeles, with a demand that we surrender our Board to their cosmetic plastic surgery Board. Meetings with attorneys from the two (2) groups and the District Attorney's Office were held, and a ruling was made that the Board of Cosmetic Surgery was formed by our organization first, and the plastic and reconstructive surgeons had to desist all activities with their Board. Because they were unable to have their own Board of Cosmetic Surgery, they "changed their tune", and they took the position that there was no need for a special Board of Cosmetic Surgery. They, again, went back to the position that the training in their two (2) year program was sufficient. The plastic and reconstructive surgeons have consistently tried to discredit our Board of Cosmetic Surgery through a national mass media campaign.

The false message that they promoted, and continue to promote, to the public, is that their program is a seven (7) year training program; but, in reality, only two (2) years are involved with a plastic and reconstructive surgery residency. In two (2) years, their residents have to strive for proficiency in hand surgery, burn surgery, head and neck cancer surgery, transsexual surgery, maxillofacial surgery, hair lip and cleft palate surgery, skin grafting, trauma surgery, skin surgery, cranio-facial surgery and, cosmetic surgery, including liposuction surgery. Our position is, that board certification in plastic and reconstructive surgery does not necessarily mean that the doctors are experienced and competent in cosmetic surgery.

We all know, in this day and age, that beginning a new Board is a most difficult task. Many roadblocks are created by established groups, and this is the cause of the present ongoing battle between the plastic surgery group and the cosmetic surgery group. No Board, that was ever established, was able to begin in a totally satisfactory academic and practical fashion.

Almost fifty (50) years ago, when a group of surgeons decided to form a Board of Plastic & Reconstructive Surgery, they used the same methods that we are employing, i.e., gathering surgeons from various surgical specialties, who had practices with an emphasis in reconstructive surgery. These surgeons were also grandfathered in as Board certified. It is a well known fact that it took many years for the American Board of Plastic and Reconstructive Surgery to become an integral part of American medicine and be accepted by the American Board of Medical Specialists.

Never in the history of medicine has any one group attacked another group in such a vicious manner, through the mass media, as the plastic surgeons have attacked the cosmetic surgeons. Examples of slanderous articles are attached as Exhibit "B". The plastic surgeons instituted a massive publicity campaign, spending hundreds of thousands of dollars, to discredit the new

Board of Cosmetic Surgery. It is obvious to the cosmetic surgery group that the plastic surgeons are not concerned to protect the public, but rather their selfish motive to protect their own "turf". The plastic surgeons have attacked the cosmetic surgeons for unethical advertising, and yet at the same time Board certified plastic and reconstructive surgeons have carried out unprecedented advertising to entice the public and seek their patronage. In Exhibit "C", there are a number of full page unprofessional advertisements in magazines which are those of Board certified plastic surgeons.

There is no group of doctors in any one (1) specialty that have all the answers to perfect medical services, nor are all the finest surgeons in any one (1) group. There are all levels of quality in our organization, as is true for the general plastic surgeons organization. As a matter of fact, in a recent study done in California, the percentage of malpractice cases against plastic and reconstructive surgeons are equal to those surgeons from various other specialties. The malpractice fees for both plastic and reconstructive surgeons and cosmetic surgeons are similar.

We take great pride in the establishment and growth of our Board. Our written and oral examinations are established to accept and pass only those doctors with the finest credentials, the most adept surgeons with the best academic knowledge. We are proud of our record, and we take umbrage with the false statements made by the plastic surgeons, that ours is a "diploma mill". The rate of passing those taking the Boards in cosmetic surgery is approximately sixty percent (60%), and our requirements for admission to the Board set standards so that only those doctors truly qualified will be accepted. Attached as Exhibit "D" are the qualifications for our Board examinations, which set stringent requirements, and this is especially true considering there were no truly comprehensive and adequate training programs available for doctors in cosmetic surgery.

Despite charges to the contrary, candidates who apply for Board certification in cosmetic surgery must have primary Board certification in any one (1) of the following specialties:

1. Otolaryngology/Head and Neck Surgery
2. General Surgery
3. Plastic & Reconstructive Surgery
4. Gynecology
5. Dermatology
6. Ophthamology
7. Maxillofacial Surgery with M.D. and D.D.S. degrees

When we inaugurated our Board examination, we also established formal one (1) year fellowship programs in cosmetic surgery. As in the formation of all new Boards, it was initially difficult to begin residency programs. We now have five (5) one-year cosmetic surgical fellowships and three (3) one-year dermatologic cosmetic surgical fellowships.

Beginning in July of 1990, we will have the first two (2) year residency program in cosmetic surgery. These residencies will be at the Mt. Sinai Hospital, a Graduate Health System Affiliate, in Philadelphia, PA, and The Straith Clinic in Southfield, Minnesota. Attached is Exhibit "E", which are the Board of Cosmetic Surgery Guidelines, their operative record folder, and a list of our current Fellowship and Residency training programs.

Surgeons who enter our Fellowship or Residency training programs, they must have a primary prior residency in any one of the following specialties:

Otolaryngology/Head & Neck Surgery
General Surgery
Plastic and Reconstructive Surgery
Gynecologic Surgery
Dermatologic Surgery - Must have one (1) year of general surgery.
Maxillofacial Surgery - Must have an M.D. & D.D.S. degree and one (1) year of general surgery.

We realize that many cosmetic surgeons who have taken our Boards in the past did not have formal training programs. This was because such training was not available at the time, because cosmetic surgery is, in reality, a very young specialty. Most cosmetic surgeons today, in the United States, whether they are members of our group or members of the plastic and reconstructive surgery group, were basically self trained, because their residency programs contained little or no training in cosmetic surgery. Attached as Exhibit "F", are articles published in plastic and reconstructive surgical journals outlining the deficiencies of cosmetic surgical training in their programs.

We realize that changes have to be made on an ongoing basis in order to upgrade American medicine with updated medical knowledge and to introduce new cosmetic procedures. Over one (1) and a half (1/2) years ago, the Board of Trustees of our organization discussed the concept of subcertification, and we re-established the need for necessary changes in order for our Board to have the highest possible standards.

It is with pride that I can report to this Subcommittee, that beginning with our Board examination in January of 1990 we will certify doctors in cosmetic surgery, as hereinafter set forth in Section I, and we will sub-certify doctors in any one or a combination of the following areas under Section II, hereinafter as follows:

I. Certification

   Cosmetic Surgery

II. Subcertifications

   1) Facial Cosmetic Surgery
   2) Body & Extremity Cosmetic Surgery
   3) Facial Liposuction Surgery
   4) Body & Extremity Liposuction Surgery
   5) Dermatologic Cosmetic Surgery
   6) Cosmetic Breast Surgery
   7) Ophthalmic Cosmetic Surgery

8) Laser Surgery

If a candidate wishes to become certified in cosmetic surgery, and be listed as a Board certified cosmetic surgeon, he will have to pass his oral examinations in categories No. 1 through No. 7.

In the subcertified areas, the candidate will be able to take an examination in any one of the areas of subcertification, No. 1 through No. 8, or in a multiple thereof. The physician's certificate will set forth that he or she has successfully passed the examination, and the doctor will be sub-certified in that particular area. In order to be listed as a Board certified cosmetic surgeon, all subcertification areas, No. 1 through No. 7, must be passed successfully. See attached Exhibit "G", Board Requirements.

The Board of Cosmetic Surgery has also made a far reaching decision concerning doctors who apply for Board certification that do not have hospital surgical privileges. If the doctor's surgery is entirely office based, with no hospital affiliation, the doctor will have to, prior to his acceptance to take the examination, be examined by a team of two (2) certified cosmetic surgeons. They will evaluate the applicant's surgical facility, observe his surgery, review the doctor's record keeping, and evaluate the entire operation of the facility. The examiners will then submit a report to the Board stating whether they feel the applicant has the proper facilities to qualify to take the Board exams. I do not know of any Board who has, or is contemplating, such a review system for doctors who have no hospital privileges.

We strongly encourage that office based surgical facilities be accredited by an organization such as the Accreditation Association for Ambulatory Health Care (AAAHC). It is a well known fact that many office based surgical facilities are not adequate. This includes both cosmetic surgeons, plastic and reconstructive surgeons, as well as other surgical specialties. Currently, a few states have instituted State Guidelines, and it is our position that a national program is ideal. This would create equality throughout the country, a goal we feel is a necessity. We support such a program, either voluntary or involuntary. The American Board of Cosmetic Surgery is working closely with the American Academy of Cosmetic Surgery to encourage accreditation of office based surgical facilities.

I give my personal commitment, as President of the American Board of Cosmetic Surgery, to do everything in my power during the next two (2) years, which is the term of my office, to establish our Board as the premier Board for cosmetic surgeons, both in certification and subcertification. We are developing the first program of peer review of any major surgical specialty. We will evaluate our surgeons in five (5) year intervals, and we will require an update of their practice, so that the public will have an opportunity to know exactly what the activities and abilities are of each doctor in his or her particular specialty.

I wholeheartedly agree with this Committee, that the consumer must be protected, and we should disband the outdated concept of caveat emptor (buyer beware). Our group is dedicated to create the specialty of cosmetic surgery as an accepted and well recognized specialty. The American Board of Cosmetic Surgery needs protection from the American Society of Plastic and Reconstructive Surgeons, and they must refrain from their continued smear campaign to discredit our organization. I hope this Committee will realize the necessity for the specialty of cosmetic surgery.

The American Board of Cosmetic Surgery, Inc.

159 East Live Oak Avenue, #204
Arcadia, California 91006
(818) 447-1579

President
Julius Newman, M.D.
1488 City Line Avenue
Philadelphia, PA 19151
(215) [illegible]

May 12, 1989

Congressman Ron Wyden
Chairman, Subcommittee on Regulation,
Business Opportunities, & Energy
House of Representatives
2361 Rayburn House Office Building
Washington DC 20515

Dear Congressman Wyden,

Now that some of the dust has settled and I've had a chance to reflect on the activities of the Congressional Hearings, I truly feel that the important outcome of the Hearings was the fact that there had to be changes made by all groups involved in the practice of cosmetic surgery. Because of the publicity and media coverage there is no question that changes have to be made and I'm happy to say that the American Board of Cosmetic Surgery and the American Academy of Cosmetic Surgery has taken a positive approach to correcting various areas to truly protect the consumer.

The American Board of Cosmetic Surgery and the American Academy of Cosmetic Surgery presented an array of changes that showed our concern about the problems in the specialty. I for one have initiated many changes that I feel are beneficial to the patient seeking competent surgeons in cosmetic surgery.

On the other side of the coin, I am deeply upset by the thrust of the plastic surgeons in deriding our organization as dishonest and misleading in our activities. The plastic surgeons tried to paint a picture that they were honest, pure, forthright, and that all the doctors in their organization had impeccable credentials and that our doctors were of poor quality and dishonest.

I just received the Clinics in Plastic Surgery dated April 1989 of which this volume is strictly on Lipoplasty. I have xeroxed a copy of the front page of the journal and a copy of the preface by Dr. Richard Mladick. In the last paragraph he states "...the leading article is by Dr. Illouz, the father and innovator of lipoplasty." Dr. Illouz is not a trained plastic and reconstructive surgeon, and never took any formal training in cosmetic surgery, and never passed any boards in plastic and reconstructive surgery.

There is a xerox copy of the first page of the lead article in which Dr. Mladick, the Guest Editor, states that Dr. Illouz gave his first presentation in the United States in October 1982 which is an outright lie. At the bottom of the page there is an asterick which states "Traveling Professor", French Society of Aesthetic Plastic Surgeons, Paris, France. To make a statement that he is a traveling professor is the most ridiculous statement I've ever heard. There is no such thing as a traveling professor, he does not have any formal title as a professor, and this is a totally misleading title. For them to make such a statement in their prestigious text is incomprehensible. It is clear that they do what is good for them, but what the cosmetic surgeons do is all bad. This truly is a sad state of affairs.

I went into my files to gather more data for you. I did not want to bring this all out because I felt that it really is silly to get involved in a battle of organizations. I think it's time that you saw the real truth behind the falsities that the plastic and reconstructive surgeons have tried to foster on the public and on your committee. I enclose a copy of a Lipoplasty Newsletter from the Fall of 1986.

On page two there is a statement that Greg Hetter, Adrien Aiache, and Fred Grazer went to Paris in June 1982 to observe Illouz' technique. Members of our Academy visited Dr. Illouz prior to June 1982, as a matter of face, we had Dr. Illouz as a Guest Lecturer at our January 23, 1982, meeting at the Century Plaza Hotel, which predates by six months their trip to visit with Illouz.

On page two they state that they conducted the first course on lipoplasty in February of 1983, this is wrong. Enclosed is a xerox copy of our brochure for a live operating room workshop on suction curettage for body fat which we gave October 3-6, 1982. This predates, what they say is, the first course in lipoplasty in the U.S. by five months.

They state that at the meeting at the Century Plaza Hotel they formed the Lipolysis Society, the presidency started in the spring of 1983. The exact date of incorporation is not mentioned. I am enclosing a copy of the incorporation of the American Society of Liposuction Surgery and you will see that was done in December of 1982, which again, predates their society and makes us the first society of its kind in the U.S.

On page two they sate in October, 1983, they had their third basic training symposium but I do not see any date of their second symposium. Our second and third international workshop which was held in June 1983 and August 1983 which again predates their workshop of October 1983.

On page four there is a letter "Dear Carson" from Dr. Wilkinson and at the bottom of that letter there is an absolute unequivocal derogatory remark about gynecologists performing liposuction surgery.

On page nine there is a letter from a plastic surgical resident and at the bottom of this letter, in the first column, he discusses plastic surgeons taking time from their practice to attend a two day symposium and he questions whether residents should take the course, and the answer was yes, especially since only a handful of professors in teaching programs have taken liposuction instruction. There is no question that our workshops are equal to or even better than what are put on by the plastic and reconstructive surgeons. The other point is that they admit that their residents coming out of their training programs are not trained in liposuction surgery because the chiefs in their departments are not trained.

There are two pages showing their aggressiveness in supplying brochures, photographs, advertising, and soforth. They are supplying members with pre and post operative photographs and allowing them to use this in their promotional talks and presentations to get patients. This is something that we have not done.

On page twenty-four you will note that they make comments as to who should have hospital privileges in lipoplasty and there again are derogatory statements made of otolaryngologists, gynecologists, general surgeons, and dermatologists.

I also enclose a copy of a letter from the Lipolysis Society to patients that called in to the Society seeking referring doctors who perform liposuction surgery. To read this letter, you can easily see that they were not out to protect the patient, they were out to promote patients for their organization. Look at some of the statements in the first paragraph where they state "revolutionary plastic surgical technique perfected by Lipolysis-trained, board-certified plastic surgeons performing body contouring". Here they are promoting doctors who only took a two day course.

In the next paragraph Dr. Lewis states that Dr. Illouz is a French plastic surgeon, which is an outright fabrication of the truth. He is nothing more than a surgeon who did gynecologic procedures and abortions and had no formal plastic surgical training.

In the next paragraph he states that they have obtained internationally recognized training. My question is recognized by whom. In the same paragraph he talks about other doctors who are not thoroughly trained, while at the same time, all the plastic and reconstructive surgeons learned the technique of liposuction from a two or three day workshop.

In the last few paragraphs you can see the pitch to get patients to come in and receive this revolutionary surgery.

I really had to set the record straight because it truly is an injustice for one group in medicine to deride and condemn another group because of the desire to control the field of cosmetic surgery and limit competition. I think it's about time that the plastic and reconstructive surgeons stop this ruthless attack on the cosmetic surgeons.

I thank you for the time that you have taken to read this letter, and I want to reassure you that I have put my heart and soul in the past ten years to create the specialty of cosmetic surgery. I feel that we have come a long way in a short period of time, and doing, what I think, is a good service for the consumer. We have our shortcomings and we know it, but we are doing constructive work to protect the public.

Sincerely yours,

Julius Newman, M.D.

c.c.: R. Caleel, D.O.
R. Webster, M.D.
F. Papineau

Requirements for Certification and Subcertification

American Board of Cosmetic Surgery

Application Requirements

Those applying for Cosmetic Surgery Certification or Subcertification who have not completed an official residency or fellowship must have performed a minimum of 250 cosmetic surgical procedures in the full year prior to application. In addition, candidates must have been performing surgery in their specialty for the past five years and must have completed a total of at least 1,000 cosmetic surgical procedures.

Candidates applying for full certification must pass an oral examination in each of the Subcertification Categories 1 through 7.

Candidates applying for Subcertification must have performed at least 50 procedures in each category for which they are applying. Each group of 50 procedures is counted toward fulfilling the minimum 250 procedure requirement. Candidates must pass the oral examination in the category for which they are applying.

Doctors who have already received Subcertification Certificates and wish to add Subcertifications in other areas must submit pre and post operative photographs and case histories of 50 surgical procedures done within the past year in each category for which they are applying. Candidates must also submit a letter of recommendation from facilities where they received training in the categories to which they are applying. Candidates must pass the oral examination in their new areas of subcertification. They are not required to take the written examination again.

All candidates will take and must pass the same written examination. Candidates applying for Subcertification will be expected to have a general knowledge of cosmetic surgical procedures outside the area of Subcertification to which they are applying.

Every candidate must submit letters of recommendation from the chairperson of his or her residency training program and from the departmental chief at his or her current hospital facility.

Candidates who have no hospital operating room privileges and who perform all surgical procedures in their offices will be visited by a team of cosmetic surgeons who will inspect their surgical facilities, observe and evaluate live procedures, and examine patient records. The cost of this required visit will be paid by the candidate.

One Year Approved Cosmetic Surgery Fellowship

Candidates may take the written examination upon completion of the training program. To be eligible for the oral examination, they must complete at least 500 cosmetic surgical procedures as primary surgeon. There are no time constraints for completion of the procedures requirement.

Two Year Approved Cosmetic Surgical Residency

Candidates may take the written examination upon completion of the training program. To be eligible for the oral examination, they must complete at least 250 cosmetic surgical procedures as primary surgeon. There are no time constraints for completion of the procedures requirement.

Eligibility Requirements

Candidates must be board certifiied in one of the following specialties (Cosmetic Surgery Fellows and Residents must be eligible for board certification in their primary specialty):

- Dermatology
- General Surgery
- Gynecology
- Maxillofacial Surgery (with dual M.D./ D.D.S. degrees)
- Ophthalmology
- Orthopedics
- Otolaryngology/Head & Neck
- Plastic & Reconstructive

Subcertification Categories

Subcertification is available in the following areas:

1. Body & Extremity Cosmetic Surgery
2. Body & Extremity Liposuction Surgery
3. Cosmetic Breast Surgery
4. Dermatologic Cosmetic Surgery
5. Facial Cosmetic Surgery
6. Facial Liposuction Surgery
7. Ophthalmic Cosmetic Surgery

Additional Subcertification is available in these categories:

8. Cosmetic Laser Surgery
9. Maxillofacial Surgery

Additional Information

There is an examination fee of $800 which covers both the written ($400) and oral ($400) examination fees. Upon successful completion of both examinations there is an additional charge of $350 for your certificate. Doctors applying for Subcertifications in new areas will be charged a total fee of $450 for each new area.

Oral and written examinations are given annually prior to the Annual Scientific Meeting of the American Academy of Cosmetic Surgery in Los Angeles, California.

Candidates who meet the requirements should direct a written request for the Board examination application to the American Board of Cosmetic Surgery, Inc., 159 E. Live Oak Avenue, Suite 204, Arcadia, CA 91006
Telephone: 818-447-1570.
FAX: 818-447-7880.

TESTIMONY
ON THE SUBJECT OF COSMETIC SURGERY

Bruce B. Chrisman, M.D., FIACS
1319 Punahou Street
Suite 1070
Honolulu, Hawaii 96826
April 4, 1989

TO: Committee on Small Business
U.S. House of Representatives
2361 Rayburn House Office Building
Washington, D.C. 20515

Dear Chairman Wyden and Honorable Members of the Committee:

Thank you for the opportunity to testify on my experience, and strong opinions about, the subject of cosmetic surgery. My original residency training (1971-74) was in the field of Dermatology, yet my medical practice has evolved, after a number of years of post-graduate training and experience, to one which is almost exclusively Cosmetic Surgery. I am the Section Head for Dermatology of the American Academy of Cosmetic Surgery (AACS). I thus come before you as a representative of the field of Dermatology for that group. I am also on the Advisory Board of the American Society for Liposuction Surgery, a group closely associated with the AACS, as well as a Board Examiner for the American Board of Cosmetic Surgery, another group closely associated with the AACS.

Although I am not officially representing them at these hearings, I am also on the Board of Directors of the American Society for Dermatologic Surgery (ASDS), and I speak unofficially for my hundreds of peers in the specialty of Dermatology, whose aspirations and complaints about their opportunities to compete in the field of medicine have come to my ears for years. I am also a full Fellow of the American Academy of Facial Plastic and Reconstructive Surgery (AAFPRS, a large subgroup of ENT-Head and Neck Surgery), one of the few dermatologic surgeons to hold this status, and I teach and speak at the national and international meetings of each of these three major surgical groups (AACS, ASDS, AAFPRS).

Please allow me to present further personal qualifications for this testimony:

1. Board-Certified, American Board of Dermatology, 1974.
2. Board-Certified, American Board of Cosmetic Surgery, 1983.
3. Full Fellow, American Academy of Dermatology, American Society for Dermatologic Surgery, American Academy of Cosmetic Surgery, International Academy of Cosmetic Surgeons.
4. Associate Clinical Professor (Dermatology), John A. Burns School of Medicine, Honolulu.
5. Author of 17 articles and book chapters in the medical literature, all but two on cosmetic surgery and procedures. A significant number of them are on liposuction and on the practice of outpatient cosmetic surgery.
6. Contributing Editor for cosmetic surgery, The Journal of Dermatologic Surgery and Oncology.
7. Contributing author on cosmetic surgery for the journal "Cosmetic Dermatology".
8. Frequently an invited speaker at national and international cosmetic surgery meetings.
9. Co-chairman (1986) for a major liposuction training workshop.
10. One of the preceptors (the only one from Dermatology) of the cosmetic surgery Preceptorship training program of the American Academy of Cosmetic Surgery.

Dermatologists in Cosmetic Surgery

The large majority of cosmetic surgery involves surgery of the skin and its subcutaneous tissues, and certain skin appendages (hair follicles and breasts). No where can a better background be found for such specialized surgery of the skin than in the field of Dermatology, where residency training encompasses extensive training in the physiology, diseases, and treatment of the skin, including surgical treatment by a number of modalities.

Over the past 30 years, the specialty of Dermatology has undergone great changes, either unseen or purposely ignored by the large majority of physicians in other specialties. Many of these physicians still think of Dermatology as falling strictly into the great division of the field of Medicine known as "medical" specialties, as opposed to the other great division; namely, "surgical" specialties. One of the reasons for this is that these physicians traditionally call upon the more clinically-oriented dermatologists to treat the skin lesions and diseases of their families and their patients. Since the specialty of Dermatology has long been office-based, specializing in economical outpatient care, not hospital care, the new highly developed opposite pole of Dermatology, its surgical pole, is little known by these other physicians.

Yet the truth is that Dermatology straddles the fence between the two great divisions in Medicine--it is unquestionably a medico-surgical specialty now, not too different from ophthalmology (eye diseases and surgery), having some members who are very clinical and do only the more minor surgery, and other members who are very surgical and do much more major surgery.
Like myself, they may practice almost nothing but surgery, including major skin cancer surgery, extensive hair replacement surgery, and even other cosmetic procedures such as facelift, breast implants, and liposuction.

This all began in the late 1950's with the development of hair transplants and facial dermabrasion by dermatologists. Another huge impetus toward more surgery in the specialty was the development of Mohs' surgery for serious skin cancers in the 60's and 70's, by dermatologists. From close liaison with colleagues in the field of otolaryngology (ENT)-Head and Neck Surgery, these dermatologic surgeons learned advanced plastic surgical techniques to treat the sometimes massive facial wounds resulting from major skin cancer removals. Since then they have taught these techniques to their dermatologic colleagues in articles, texts, residencies, workshops, and meetings. By the late 70's, more major hair replacement techniques involving surgical scalp reduction and major flaps of scalp tissue were developed in Dermatology.

At the same time, the public became more sophisticated, and began to demand true cosmetic surgery quality--even for the results of skin cancer surgery, prompting large numbers of dermatologists to seek post-graduate training to sharpen their surgical skills.

Thus, so-called "plastic" surgery and cosmetic surgery gradually took their place in Dermatology, while at the same time many of its traditional "medical" realms (venereal diseases, collagen diseases, pediatric dermatology, allergy) were being absorbed by other specialties. Dermatology's residency programs now reflect these changes, teaching far more surgery (and its ancillary procedures such as various forms of sedation and anaesthesia) than they used to. Many of these programs now have specific Directors of surgical training, and some of these now hold joint titles at major university medical centers; i.e., "Professor of Dermatology and Surgery".

It is clear that Dermatology has changed dramatically in its surgical aspects, especially in the past decade, and cosmetic surgery, much in demand by the public, has naturally evolved within the specialty to the point that some of the residencies already teach advanced techniques in facelift, hair replacement, liposuction, and the like. With their skin-surgery skills and their great knowledge of the skin and its associated structures, it has been relatively easy for surgically-oriented dermatologists to learn many of the procedures of cosmetic surgery, and those procedures are now well a part of the specialty's surgical texts and journals.

With excellence in skin surgery now commonplace in Dermatology, is it any wonder that a pleased skin-surgery patient seeks cosmetic surgery from the same dermatologist who performed the excellent skin surgery? Adding to this momentum of the public is the long-standing expertise of dermatologists in performing their surgical procedures on an outpatient basis, at greatly reduced cost as compared to the hospital or even the Surgicenter, and with less physiology-altering drugs than their colleagues in other specialties commonly use for such surgeries. Even more important is that there is much less risk of infection for "clean" type procedures (such as cosmetic surgery) in the outpatient setting, as opposed to the same type of surgery in the hospital setting (Whitaker: presented at the national meeting of the ASDS, 1984).

However, it is of significant note that, even though the practice of small and large cosmetic surgery has grown rapidly in the field of Dermatology, only a relatively small percentage of its members actually do the larger and more complex cosmetic surgeries at the present time. Part of this is due to the personality "set" of the group as a whole, and part is due to the large amount of personal effort and sacrifice necessary to learn these procedures in the postgraduate situation. As more and more of the Dermatology residencies teach advanced skin surgery and cosmetic surgery, a larger number of dermatologic surgeons in the future will be taking their rightful place in the multi-specialty field which is Cosmetic Surgery.

Nonetheless, the considerable and sometimes unique skills of dermatologic surgeons have been recognized for some time by other specialties:

1. Ten years ago (1979), the Third International Symposium on Plastic and Reconstructive Surgery of the Head and Neck was co-sponsored by the ASDS (Dermatology Surgical Group) and the AAFPRS (ENT-Head and Neck Surgery group).
2. Well-known dermatologic surgeons have long been "drawing card" faculty members for major national and international multi-specialty training workshops, especially those of the most closely related specialty--ENT-Head and Neck Surgery.
3. The Presidency of the American Academy of Cosmetic Surgery, a large multi-specialty group, rotates by specialty such that about every 4 years the President is from the specialty of Dermatology.
4. The three main groups making up the membership of the American Academy of Cosmetic Surgery (now more than 1200) are ENT-head and neck surgeons, plastic and reconstructive surgeons, and dermatologic surgeons. The AACS has only 3 Section Heads, one from each of these groups.
5. The Board of Examiners of the American Board of Cosmetic Surgery is made up of members from the fields of Plastic and Reconstructive Surgery, ENT-Head and Neck Surgery, and Dermatology. The Examiners examine applicants from the various specialties, not just their own group.

6. Dermatologic surgeons have long published articles in the surgical journals of other specialties, particularly Plastic Surgery and ENT-Head and Neck Surgery, and have been authors of book chapters in their textbooks.
7. Dermatologic surgeons are frequently invited speakers at the national and international meetings of other surgical groups.
8. Certain dermatologic surgeons have been able to overcome the vast inertia and politics of medicine to gain hospital privileges in "overlap" procedures previously reserved to other specialties.

My Own Experience as a Dermatologist Who Became a Cosmetic Surgeon

Fifteen years ago when I went through residency training in Dermatology, I received only a limited amount of cosmetic surgery training; i.e, hair transplants, dermabrasion, tattoo removal, and surgical removal of skin lesions. Since that time, I have devoted a great deal of time, effort, and personal expense to the pursuit of knowledge in the field of cosmetic surgery on a post-graduate basis, and I believe that I have become an expert not only in a number of cosmetic procedures, but also in how to acquire, as well as train, expertise in these procedures.

Although I have performed literally thousands of small and large cosmetic surgeries over the years, I am considered an interloper and "not even a surgeon" by many Plastic and Reconstructive Surgeons because of my original specialty, and I have observed more than ample personal and national evidence that they would like to see myself and my dermatologic colleagues removed from the opportunity to compete with them in the field of medicine, insofar as the fields of skin surgery and cosmetic surgery. It has been slow and tedious but I would submit that my post-graduate training in cosmetic surgery has given me skills, for the proceduresI perform, equal to at least the average of such skills as produced by formal residency programs which teach them in this country.

Despite what might be called a very vulnerable position in the field of surgical politics, and the hostile attitudes of many general plastic surgeons, I have never been sued. I have now performed over a hundred facelifts without a single serious complication, a statistic far better than any reported for this procedure in the medical literature of the specialty of plastic surgery. Also, in fifteen years of practicing outpatient surgery, I have never had to admit a single patient to the hospital for any reason. I believe this record speaks well for the exemplary training in cosmetic surgery which can be obtained in this country by any astute physician with a suitable background (and again I believe that the field of Dermatology provides a splendid background). This is because the training programs and workshops are very often taught by the top national and international experts in any given procedure, so as to attract attendees to these workshops and insure training quality. The resultant training is superb because of the vast experience with both the cosmetic procedures and their complications which these teaching experts bring with them to the meetings and workshops.

The bottom line is this: The term "cosmetic surgery" has become ubiquitous, a household word. The field of cosmetic surgery is likewise a generic field, and it is no longer the province of just one specialty (Plastic and Reconstructive Surgery), nor is the expertise in this field contained within that one specialty. Certain procedures within this field are performed now by dermatologic surgeons, ENT-facial plastic surgeons, gynecologic surgeons, general surgeons, and occasionally even orthopedic surgeons and others. The American Society of Plastic and Reconstructive Surgery and many of its members have enjoyed being the "in" group for many years, as far as being the providers of cosmetic surgery. This is simply no longer the case, yet they have spent vast sums of money trying to convince legislators such as yourselves and others, the public, and anyone else that will listen that they are the only group properly trained and qualified to perform cosmetic surgery. These expenditures have even required large mandatory contributions from the many members of the ASPRS.

I am not unique. I wear no halo. But I have learned to do many of the procedures in the realm of cosmetic surgery safely and well, simply because I am artistic and became intensely interested in this field, giving up many other things, including income, in order to learn it. In the field of Medicine, change is inevitable just as it is in all other aspects of our lives. When newcomers and new ideas come upon a field as conservative and entrenched in "systems" as the field of Medicine, there have always been criticism, attempted blockage, and/or ostracism. Medical greats such as Lister (germ theory and sterile technique) and Freud (psychiatry) are but two examples of ideas who time had come, yet which were greatly resisted by medical peers at the time. The same holds true for cosmetic surgery, as performed on an outpatient basis and by an increasing number of specialties.

I have experienced the same criticisms mentioned above, even from clinically-oriented members of my own specialty, as well as blockages or ostracism, even from former friends, because I have seen fit to make the considerable effort necessary to evolve as a physician and follow the personality, ethical and eye-hand talents necessary to become a good cosmetic surgeon. Yet nowhere does the criticism, blockage and ostracism of myself and my colleagues--not to mention demeaning, libel, slander and outright attempts to create public distrust and even malicious medical lawsuits--show itself to anywhere near the extent that it does from certain plastic and reconstructive surgeons, and their national group, the American Society of Plastic and Reconstructive Surgeons (ASPRS). This is of course the one specialty group whose prestige and economic well-being is severely threatened by the emergence of competitors in the field of Cosmetic Surgery (most notably from Dermatology as well as ENT-Head and Neck Surgery).

Again, I state these things as my own emphatic opinion, based on long experience, observation, and discussion with numerous other affected physicians. Yet I strongly believe these opinions are based on provable fact, adversely affecting literally thousands of physicians, and I urge this Committee to see to it that the Federal Trade Commission resume its investigations into this onerous situation, on a nationwide basis. The overt and covert restraint of trade that will be uncovered will be utterly amazing. Any of you may contact me for further details if you so desire.

Considerations for the Committee and for Congress

Congress, in its wisdom, may seek to counsel and assist American medicine insofar as this rapidly growing realm of cosmetic surgery. But to create strict guidelines or specialty categories which would fly in the face of the rapidly developing changes in this field, which have occurred in the last fifteen years or so, would only contribute to that rigid compartmentalization of Medicine in general which has been occurring more and more on the part of hospitals, insurers, and even organized medicine, in seeking to protect their own interests at the cost of the very vigor and creativeness which has made American medicine the best and most famous medicine on Earth. The overall track record of American medicine has been literally phenomenal. I implore you all as members of Congress not to seek to stifle that very assertiveness which has made American medicine great. The field of cosmetic surgery as a new medical specialty is just now truly emerging. Like any major new entity, it is suffering growing pains, yet the long history of American medicine suggests strongly that these pains will be overcome, and that the American public, and very likely the public of the rest of the world as well, will benefit from the vision and strength of the founders of this new specialty.

Another key point: all physicians, male and female, go through the same four-year medical training after college. Beyond that, while still in their twenties, they must try to decide what specialty they will further train in, and likely stay with (or very near) for the rest of their lives. Even as our medical system now exists, doctors must live, sometimes painfully, with the career decision that they have made at an early age due to the "cubby-holing" system I have described above. Dividing physicians up into neat little groups makes it easier to train them, to label them, to pay them insurance fees based on specialty, or to grant hospital privileges traditionally based on specialty rather than capability. Nowhere else in American society are our best creative minds asked to stay within one field life-long, if they discover another one to which their inborn talents are better suited.

There are those groups, particularly the American Society of Plastic and Reconstructive Surgeons, which would like to see the status quo preserved at any cost, because it is in their own interest to do so. These plastic surgeons must have hospital privileges because of the various procedures which they must do there. Couched within the "old boy" system of our hospitals, they often find it easy to prevent competitors from getting such privileges when it comes to "overlap" procedures in cosmetic surgery. They then claim, with seeming altruism, that their competitors who do not have hospital privileges should not be allowed to practice cosmetic surgery on an outpatient basis. The Committee needs to understand that this tactic is being used on a nationwide basis, and also needs to understand that hospital privileges are not granted by objective hospital administrators, but by physician committees of sometimes blindly bigoted and utterly rigid "old boy" members devoted to maintaining the status quo and protecting their own interests within the hospital. The current system is quite totalitarian as well, and the guidelines of national groups such as the AMA are often ignored.

While the American Society of Plastic and Reconstructive Surgeons (ASPRS) has remained exclusionary in both its contact with competitors and its own training programs, the very large and rapidly growing competing organizations (American Academy of Facial Plastic and Reconstructive Surgery, American Academy of Cosmetic Surgery, American Society for Dermatologic Surgery) have welcomed and taught the physicians from various specialties with the integrity, interest, and skills necessary to perform cosmetic procedures. At the same time that the ASPRS has been decrying its competitors, some of its major leaders have written journal articles describing the lower quality of applicants for residency in that specialty, and the lack of enough cosmetic surgery training within that specialty. Despite opposition, the training in cosmetic surgery within the competing groups has become better and better. This is much to the public's benefit, because excellence within this new field does not belong to any one specialty, in either teaching or practicing it.

Ironically, the numerous efforts of the ASPRS to hamper and restrict its competitors--to make insurance coverage and hospital privileges more difficult for them to obtain, to make the threat of law suit more onerous for them, to tout that they are recognized by the American Board of Medical Specialties, while making every effort to ensure that their competitors are not--have acted to push these competitors further and further into the field of outpatient cosmetic surgery, thus unlocking the door of competition in the field of Medicine, and creating the availability of much less expensive cosmetic surgery for the average American citizen.

Many physicians still "look down their nose" at cosmetic surgery, deeming it frivolous or unnecessary within their own rigidly scientific sphere of practice and treatment. Yet psychiatric studies, as well as my own long experience, have shown that cosmetic surgery can be at least as effective at rebuilding the character and moral of an individual as can extended counseling or psychotherapy. As American medicine has become more "holistic", more and more recognition has been given to the fact that self-image is just as important to the well-being of an individual as is the health of their gall bladder, appendix, heart, etc.

Cosmetic surgery is unique within the broad field of medicine in that its services are elected--chosen rather than needed by the patient. As in other areas of the American marketplace in which the public chooses what, if anything, they wish to purchase, the field of Cosmetic Surgery is now being greatly benefited by the number of new competitors, which gives the public many more results by which to evaluate true expertise, not to mention lowered prices due to increased competition. Unfortunately, many plastic surgeons have found that their ego is greatly undermined by the presence of competitors, and that their pocketbooks are even more greatly undermined when they find that their high prices are no longer acceptable to many members of the public. This has stirred many of them to negative generalizations about their competitors; name-calling; demeaning; efforts to provoke lawsuits against competitors; and efforts to create legislative, medical society, hospital, and insurance company restrictions against their competitors. In short, it has created a growing whirlwind of turf battling in the field of cosmetic surgery.

Your Committee needs to know that:

1. A nationwide effort is being made by the ASPRS to state legislatures to spur laws which will restrict their competitors under the guise of controlling advertising, disallowing outpatient surgery without hospital privileges, insurance restrictions, etc.
2. In a recent defamation and libel suit brought by a facial plastic surgeon against a general plastic surgeon in Hawaii (McCurdy v. Schlesinger), Dr. Schlesinger testified that he was taught in his plastic surgery residency that competitors were inferior, as well

as charlatans who duped the public, and therefore deserved to be blocked from practicing.

3. The most prominent member of the Hawaii plastic surgery community severely criticized dermatologic surgeons in a major newspaper article in 1982, saying that only plastic surgeons were properly trained to handle the procedures and complications involved. This same plastic surgeon recently gave up his license for six months and agreed to another year and a half of supervised practice thereafter, following the death of a patient who had been kept at his office for almost two days after something went wrong with an outpatient surgery there.

4. I once had a young plastic surgeon tell me that he would never dream of having his own outpatient surgery and did all his surgery at the hospital so that the nurses would see him and tell other people about him. The vast sums that this was costing the public yearly, let alone throughout his lifetime of practice, had totally escaped him in his egotism.

5. I know of two instances in which young plastic surgeons were threatened with not passing their Boards if they associated with non-plastic surgeon competitors, and/or that they would be kept from hospital cases and other practice growth if they did not fall into line.

6. I know of a number of highly qualified surgeons who have had great difficulty, or have failed, in getting hospital privileges for procedures which they were highly qualified to do, due to the effort of one or more plastic surgeons in their community or hospital.

7. I and another dermatologic surgeon have personally experienced grave difficulties in getting hospital privileges due to the efforts of certain plastic surgeons in our city.

8. Several major lawsuits for defamation or libel have been lost by the ASPRS or individual plastic surgeon in the country in the past several years (Georgia, Hawaii) and this has apparently led the

ASPRS even more to try to get local, state, or national policymakers in legislative bodies to create restrictions for their competitors so that that group will not be in as much risk of lawsuit if these restrictions can be created.

9. The ASPRS and individual plastic surgeons have been quick to publicize so-called "victims" with poor results, even death, amongst their competitors who do cosmetic surgery, and in some instances considerable effort and large sums of money have been spent by them in this regard, while at the same time totally failing to report or acknowledge that this exact same situation occurs within their own group. Such "victims" and deaths from cosmetic surgery are an extreme rarity, especially insofar as true incompetence or malpractice, but this is not what the public and legislative bodies are being led to believe--as a result of the "turf battle".

10. About 10 years ago, the FTC was deeply involved in investigating the actions of the ASPRS as possible restraint of trade, but administrations changed and this investigation was dropped for lack of appropriate funding. The restraint of trade situation is far worse now than it was then.

11. In 1985, the President of the plastic surgeons' Aesthetic Surgery Society commended (in their newsletter to the many members) a situation in which a plastic surgeon member had thwarted hospital privileges for a competitor who wished to do liposuction. This is openly commending and encouraging restraint of trade.

12. I am told by an informed source from your own Committee that there is evidence that the scientific Journal of the American Academy of Cosmetic Surgery, which contains a wealth of information about cosmetic surgery, has been suppressed from inclusion in the usual reference lists used by researchers and American physicians as well as physicians all around the world, as part of the same scenario I have mentioned above, seeking to thwart competition and recognition.

13. I am utterly sick of having one astute physician after another come up to me at medical meetings and tell me of the great difficulty they are having seeking hospital privileges or other medical recognition within their community or hospital, as a direct result of input or efforts by physicians from the specialty of Plastic and Reconstructive Surgery.

14. I have had three different astute and ethical plastic surgeons in my city tell me they would love to get together with me and other competitors to share training and experiences and how best to care for patients, but feel utterly constrained from this by the intense group pressure which they feel from their local society of plastic and reconstructive surgeons. I am sure that this same internal restraint of trade situation is taking place all across the country in such local societies, and within the ASPRS as a national organization as well.

The above are facts to the best of my knowledge and opinion, and I again implore your Committee to use every possible effort to get the FTC to look into the matter of restraint of trade within the field of cosmetic surgery, because they are going to find an incredible number of instances all across the country which will document this restraint of trade. This restraint of trade is greatly restricting the access of the public to quality care in cosmetic surgery, and the growth and spread of the best possible knowledge in this field, and is costing the public millions of dollars a year unnecessarily, due to restraint of competition (competition which would otherwise act to provide more access to care and lower prices).

Lastly, I would like to address the specific questions about cosmetic surgery as put forth by Chairman Wyden:

1. Regarding the dangers and obstacles faced by consumers in seeking a qualified cosmetic surgeon: "caveat emptor"--let the buyer beware--

is an axiom well known by the public in a free enterprise society such as ours. There will always be certain members of our society who are taken in by quacks and charlatans in many fields. Happily, I personally believe in the collective rationality and intelligence of our populace, which is the best educated and best informed of any populace on earth.

It is an unfortunate fact that today's medical residencies, no matter what the specialty, do not provide enough cosmetic surgery training to fully prepare a physician for all the constantly expanding procedures within that field. The American Academy of Cosmetic Surgery has just this year begun two residency programs covering only cosmetic surgery, and I would strongly predict that such residencies will rapidly proliferate in the future. The field of Cosmetic Surgery is simply too large to be fully learned as a portion of other traditional residency programs, where the exploding amount of information about that traditional specialty alone leaves little time in most residencies for truly adequate training in cosmetic surgery. In some traditional residency programs, the Chairman may feel that cosmetic surgery, since elective, is less important than the other procedures which must be learned, or may actually dislike cosmetic surgery. Thus even less of it is taught. That is why post-graduate workshops in cosmetic surgery are so common and so popular.

At the present time, the best that the public can do is to ask whether the individual physician is Board certified in Cosmetic Surgery, and also to ask repeatedly around in the community about the reputation of the surgeon being considered. This is not the only answer, and certainly not all of the good cosmetic surgeons are so Board certified.

2. Regarding the factors prompting the growing explosion of consumers who are having cosmetic surgery: this explosion is the natural outgrowth of the massive emphasis on "personal growth" and individual rights which has taken place in this country and elsewhere in recent

years. The huge interest in individual athletics and workouts, self-help seminars, books to improve mental well-being, tennis, jogging, etc. is no different than the massive interest in cosmetic surgery.

3. Are unqualified and less than adequately trained surgeons performing cosmetic procedures? Certainly this is true in some instances, but the same is true for those physicians removing gall bladders, thyroid glands, etc. Indeed, as in all other groups, there are also a few sociopaths. Surgeons are a highly trained group of individuals within our society, yet within this group there is a bell curve of expertise, just as in all other fields of science and art. There is a small number at one end who are very poor practitioners, a small number at the other end who are absolutely superlative, and large number in the middle who are more or less average. Unfortunately, given the "expose" mentality of many printed and T.V. media presentations, legislators and the public hear only about those poor quality doctors at one end of the bell curve. No one seems to mention the very large number of patients who are moderately to immensely pleased with their cosmetic surgery, tell all their friends about it, and therefore add to the mushrooming of this field. If bad practitioners and bad results were a truly frequent occurrence, would cosmetic surgery be enjoying its current immense popularity? The public is certainly not stupid.

4. Are consumers being misled to believe that cosmetic surgery procedures are virtually without risk? At times I see cosmetic surgery advertisements which overstate the safety or ease of the procedure, yet I believe we must recognize that, with "a lawyer behind every tree" and a clearly established doctrine of informed consent in this country, very few cosmetic surgeons who wish to continue to practice without losing their shirt fail to tell patients about the risk of surgery once they come in for a consultation—even if their advertising is flamboyant.

5. Is cosmetic surgery being performed in less than adequate facilities? Once again, I strongly believe that the "lawyer behind every tree" image, coupled with the very great propensity of our populace to sue over anything and everything, keeps the large majority of cosmetic surgery facilities at least adequate insofar as the "standard of care" in the furnishings and equipment which are needed. We must also remember that even the most mediocre facilities in this country far surpass the medical facilities which are considered adequate in many other countries, including Europe. We must also keep in mind that oftentimes those who have lesser facilities also do smaller procedures with less risk, and perform them with little or no ancillary medications--such medications can create complications, even severe complications or death, associated with cosmetic surgery.

6. Regarding whether consumers are being inundated with false and deceptive advertising which preys on their emotions and leads to dangerous, costly, and unnecessary cosmetic surgery: we must remember that we cannot have our cake and eat it, too. If advertising by physicians is now allowed in order to create free enterprise and lower medical prices, this same spirit of free enterprise must be allowed in the field of cosmetic surgery just as it is allowed for well-baby care, medical groups, etc. Again, I do not believe that the American public is so stupid as to believe everything they see in advertising. They are very familiar with hyperbole and overstated claims in advertising. One can hardly imagine that in an elective surgery field such as cosmetic surgery, the public would not recognize the potential for such claims and "take them with a grain of salt".

   More importantly, cosmetic surgery, as compared to other surgery and even such common things as wisdom tooth removal, appendectomy, and child-birth, has a very excellent safety record.

   Cosmetic surgery, by its very definition, is "unnecessary"--but only in the medical sense. Insofar as self-image and quality of life, it is utterly necessary in the mind of many people, particularly those who feel the constraints of aging as they take part in the social or business marketplace after divorce, changing jobs, etc.

Cosmetic surgery is moderately costly, but is a consumer choice no different than a new wardrobe or BMW.

7. Is current government overview or peer review adequate to ensure the public safety? I believe it has been quite adequately demonstrated in the past several decades that Medicine as a whole, and by individual groups, feels very strongly about the need and right to police its own realm, and has shown increasing efforts to do this. As cosmetic surgery has become more and more accepted as an outpatient type of surgery, all of the major cosmetic surgery organizations (ASPRS, AAFPRS, ASDS, and AACS) have set about trying to establish various forms of peer review and credentialling such as subspecialty certification, withdrawal of membership for improprieties, establishment of, or affiliation with, outpatient-surgery peer review groups, and the preparation of carefully considered guidelines for the performance of particular outpatient surgery procedures or the set-up of outpatient surgery facilities. In short, these groups recognize the growing need to police the safety and care provided in outpatient facilities, and to set up the systems within their own groups, rather than relinquishing it to government control.

8. Regarding whether the existing Board certification processes are an appropriate and adequate means of protecting the public from unqualified doctors: The Board certification process is one means, but not the only means, by which the public can seek a doctor qualified in cosmetic surgery. Unfortunately, none of the Boards currently recognized by the American Board of Medical Specialties can fully certify a physician in the large and growing field of cosmetic surgery, because these Boards have other testing responsibilities for the broad field by which each is named, and neither that field's residency, nor the Board exams, can devote more than a relatively small percentage of their time to the field of cosmetic surgery. Only the American

Board of Cosmetic Surgery, which examines only for knowledge in this new specialty (using stricter application criteria than any other American Board), and perhaps the new Board being developed by the American Academy of Facial Plastic and Reconstructive Surgery to test for that subspecialty, can truly substantiate qualifications in the field of cosmetic surgery.

A perfect case in point is a Board certified plastic and reconstructive surgeon with whom I am very familiar who was number one on his specialty's Board exam in the year in which he took it, yet who had a number of problems with judgement situations in the real world of surgery, and had significant practice problems including losing his hospital privileges and the respect of a number of his peers.

On the other hand, there are a number of truly excellent physicians who have never been Board certified and never will be. Perhaps they dislike the competitive testing process, have certain language barriers, or simply do poorly on formal examinations although they are excellent in the real world of surgery.

The Committee should recognize that the American Academy of Cosmetic Surgery and its affiliated American Board of Cosmetic Surgery has done more than any other group in the world to establish Cosmetic Surgery as a recognized specialty with specific needs in both training and certification. The fact that Plastic and Reconstructive Surgery is already recognized by the American Board of Medical Specialties, and that this prior existence as well as tremendous lobbying efforts make it extremely difficult for a new Board to be recognized by the ABMS today, in no way detracts from the quality of the American Board of Cosmetic Surgery. I know this because I have taken part in the Board for the past six years, and have personally examined applicants from the fields of Dermatology, ENT-Facial Plastic Surgery, and general Plastic Surgery, as well as several other specialties.

Please be aware that it took the American Society of Plastic and Reconstructive Surgery ten years to be recognized by the American Board of Medical Specialties some decades ago, even though such recognition was much easier to obtain at that time than it is now. Being a generation in the past, this history is seldom recognized by current members of that specialty and they are quick to claim that the American Board of Cosmetic Surgery is somehow less valuable than their own simply because it has not yet battled its way through the medical political process to achieve formal recognition.

Personal Recommendation to the Committee, As Requested by Chairman Wyden

1. There are a large number of cosmetic surgeons in this country, numbering in the several thousands, who spend a great deal of their time defending themselves against demeaning, slander, libel, provoked lawsuits, and media smears instigated or promoted to restrict competition. This time could be much better used in sharing experiences with colleagues, upgrading their facilities, improving their training in past procedures, and learning new procedures more effectively. The number of person-hours which could be more effectively used is mind-boggling. I know this from personal experience and from discussions and complaints from many colleagues over the years.

   Only when the vast amount of overt and covert restraint of trade currently taking place on the part of the American Society of Plastic and Reconstructive Surgery and many of its individual members is investigated, recognized, and brought to a stop will this situation, so detrimental to the growth of medical practice and the good of the public, come to a stop.

2. The government should recognize the vast popularity of cosmetic surgery, the deep human needs which make it so popular, and the likelihood of even more future growth. It should thus promote interspecialty sharing of medical knowledge about cosmetic surgery, and also workshops, post-graduate fellowships, and residencies in cosmetic surgery to the fullest possible extent.

3. Claims that a narrow and outdated residency system, in the face of an exploding amount of medical knowledge in all fields, can continue to provide all necessary education for cosmetic surgery have already been proven wrong by the existence of a number of cases like my own, in which cosmetic surgery expertise came after residency, not during it. The false and misleading claims (sometimes in public advertising) by the ASPRS that somehow they are the superior specialty which safely and appropriately does cosmetic surgery are just as inappropriate as advertised claims by any cosmetic surgeon that the procedures are virtually risk-free. Each either frightens or cajoles the public and needs to be ceased.

4. Our American hospitals are entrenched in an "old boy" medical political system of credentialling, in which certain individuals or groups within a given hospital have tremendous power to exclude or control who does or does not get hospital privileges or do certain procedures. I cannot be emphatic enough in saying that all across this country there are hundreds of physicians who are perfectly capable and qualified yet have been denied hospital privileges in cosmetic surgery, particularly from the sub-specialties of facial plastic surgery and dermatologic surgery, and that the public good is not being served by our current hospital credentialling system. These physicians, and their patients, have every right to hospital care when needed, and at this time I see no recourse but to force the hospitals to follow the guidelines for hospital privileges which have already been established by the AMA, the Joint Commission on Accreditation for Hospitals, and the American Board of Medical Specialties, which

generally state that all of an applicant's credentials, experience, and training, not just specialty, are to be considered in granting privileges.

We cannot use the criteria of the American College of Surgeons, because they seek to tell hospitals that only those doctors who are members of their "surgical" specialty groups should be given privileges in surgery. This thinking protects an "in" group, the so called "surgical" side of medicine, from the competition of an enlarging and evolving medico-surgical group, namely Dermatology and dermatologic surgery.

5. All the major surgical groups relating to the field of Cosmetic Surgery should join together to create usable guidelines for outpatient cosmetic surgery which are applicable to the surgeon doing lesser procedures as well as the surgeon doing major procedures. Unless such a coalition can be mandated for the good of the public, I believe that some of the groups, particularly the ASPRS, will continue to maintain a certain "holier than thou" attitude which prevents the best possible interplay of patient rights and needs with physician rights and needs.

Summation

In summary, the advent of individual rights as a prime concern in our society's customs and values has led to a tremendous upswing in cosmetic surgery. The emergence of a great deal of competition, much less expensive outpatient surgery, and readily available post-graduate training in cosmetic surgery has made these procedures much more available to the public, much more well known, and much more frequently done. The "in group", the American Society of Plastic and Reconstructive Surgoens, has been making a tremendous and ever-increasing efforts to restrict its competitors from other specialties, to the very great detriment of the public. This is also a great detriment to the competitors and their rights to appropriate insurance and usage of outpatient and hospital facilities for their patients, not to mention their reputations.

As outpatient cosmetic surgery has mushroomed, all the major surgical organizations involved have moved toward efforts at improving and policing this type of surgery. These efforts are best completed from within these groups, where expertise and experience are easily tapped, rather than rules and controls being forced upon the physicians and the public from elsewhere.

Training and experience in cosmetic surgery amongst the various specialties who now do these "overlap" procedures should be greatly fostered for the good of the public. At the same time, as is natural with competition, the prices will continue to come down--making these procedures more affordable for the average American.

Fair and just availability of hospital privileges for all specialists who do cosmetic surgery must become available, even if it takes special legislation to do this.

In closing, I cannot repeat earnestly or often enough that there is a vast amount of restraint of trade going on in this country in the field of cosmetic surgery and it must be stopped. Only when physicians can spend their time learning and practicing the best quality cosmetic surgery rather than defending themselves against such restraint of trade and demeaning, will the needs of the public be properly served.

Thank you for this opportunity to testify.

Bruce B Chrisman MD

Bruce B. Chrisman, M.D., FIACS

CONGRESSIONAL HEARING ON COSMETIC SURGERY

April 4, 1989

Testimony of E. Antonio Mangubat, M.D.

Mr. Chairman, members of the Subcommittee, fellow surgeons, ladies and gentlemen. I am a young surgeon who has practiced cosmetic surgery for two years here in the Washington metropolitan area. Because my practice is relatively young, I may have a somewhat skewed if not naive view of the politics of cosmetic surgery, however, I would like to thank the Subcommittee for inviting me to tell my story and I hope that my testimony will be of value to the Subcommittee's efforts to improve the safety, the art and practice of cosmetic surgery.

Let me begin by describing my professional background which is both typical and unusual for surgeons practicing cosmetic surgery today. Typical, in that I studied the art of cosmetic surgery at the side of an experienced and well known master of the craft. Unusual, in that my prior surgical experience, although extensive, was not one of the common surgical subspecialties that spawned the majority of cosmetic surgeons.

I spent two years at the University of Kentucky doing a general surgery residency, during which time I obtained a broad and extensive operative experience. As the primary operating surgeon, I performed 356 surgical procedures which included: 46 cholecystectomies (gallbladder removals), 30 breast procedures (10 of which were radical/modified radical mastectomies), 28 colon resections, and 13 gastric bypasses. I performed a total of 157 intra-abdominal operations. As the first assisting surgeon, I performed approximately 200 more procedures. I developed an interest in pediatric surgery and trauma and elected to do a one-year research fellowship in pediatric trauma at Children's Hospital National Medical Center, here in Washington, D.C. During my fellowship, I co-authored an educational grant which was funded and allowed me to stay on in the Nation's Capital. As a result, I was able to author several scientific papers, participate in the creation of four documentary and training films, write the inter-hospital pediatric transfer protocols for the State of Maryland, and create a computerized trauma data system which is currently recognized as the best system available today. This also lead to my certification as an instructor and course director for Advanced Trauma Life Support (ATLS) and Advanced Cardiac Life Support (ACLS) curricula sponsored by The American College of Surgeons and American Heart Association, respectively. As a result, I had the opportunity to teach other physicians and surgeons the essentials of emergency trauma and cardiac care, which include instruction on the essential emergency surgical techniques: Cricothyrotomy (emergency tracheostomy), tube thoracostomy (emergency chest decompression), peritoneal lavage (belly tap), and management of shock. Most surgeons will attest to the superior skill level required to perform these operations in emergency situations.

Over time, my intense interest in emergency care was tempered by the all too common conflict of a large time commitment to my work and my desire to be with my family. I have devoted most of my career to being precise and meticulous and my desire was to find a career path that would provide me with the ability to be a surgeon, which is what I most enjoy, yet maintain control over my life, which is inherently difficult to do in any endeavor of emergency medicine. Cosmetic surgery appeared to fit this mold: it was elective and could be scheduled, patients sought me out for my services as opposed to being cast into my care by fate, and I would be able to practice my first passion, surgery. After all, I have already honed my basic surgical skills on operative procedures that most surgeons would consider to be of much greater magnitude, but of no less importance, than the most complex of cosmetic operations.

From this point, like most surgeons who seek to practice cosmetic surgery, I sought out the experts in the field and voraciously read all the literature and textbooks pertinent to cosmetic surgery. I attended numerous excellent educational seminars and meetings of the American Academy of Cosmetic Surgery (AACS) of which I am currently a full fellow, and the American Academy of Facial Plastic and Reconstructive Surgery (AAFPRS). The outstanding curricula of these organizations allowed me to gain a much broader exposure to cosmetic surgical techniques not available elsewhere. I reviewed in detail and numerous times, the videotapes of many of the worlds best surgeons performing the procedures of their respective expertise, including Drs. Richard Webster, Thomas Reese, Jack Anderson, E. Gaylon McCollough, Bruce Connell, Ted Cook, Frank Kamer, Bernard Kaye, Terrence Davidson, Thomas Baker, and Jack Sheen, to name only a few. I have performed many of these procedures on cadaver preparations which in many ways is superior to live patients because once the procedure is completed, the underlying anatomy and dynamics can be further dissected in more detail, allowing a significantly better understanding of the operation.

As fate would then have it, I was introduced to Dr. Richard C. Webster by my father-in-law, Dr. Milton Henderson who happens to be Dr. Webster's personal surgeon. Dr. Webster took me under his wing and I was able to spend a considerable amount of time training at the side of one of the best recognized and well respected cometic surgeons in the world. In August 1986, I began assisting Dr. Roger Anderson, a facial plastic surgeon in this area who trained with Dr. Julius Newman, and obtained further practical experience in cosmetic surgery. In April 1987, I opened my practice in my own outpatient facility which was specifically built for practicing of the art of cosmetic surgery.

I have now been in practice for two years during which time I have operated on 246 patients performing 767 procedures. Thirty-four patients (14%) returned for additional elective surgery. Eight procedures (1.04%) were revisions of my previous work. No patients have ever required hospital admission. No malpractice suits have ever been filed or are pending against me and there have been no complaints filed with the Maryland Board of Medical Examiners. I have performed reconstructive and corrective procedures for patients with bad results perpetrated by other surgeons including board certified plastic surgeons. You have heard testimony from one of those patients, Ms. Angela Brown, earlier today. I must emphasize, however, that no surgeon is immune to bad results and I would consider it inappropriate and counter-productive to this Subcommittee's investigation to attempt to defame or malign any surgeon's character or credibility based on any single bad result. I do not pretend to know everything about my field; it is rare that any surgeon does. The field of medicine changes daily and as all diligent practitioners, I continue to learn every day. My application for board certification in Emergency Medicine is currently in progress and I am pursuing certification by the American Board of Cosmetic Surgery which I plan to achieve after completion of the required five years of practice and performing the required 1000 cosmetic surgical procedures. I consider myself a responsible surgeon who is sensitive to the needs of his patients and, judging from an honest appraisal of my results, I feel I have provided surgical services that meet and exceed today's standard of care.

The philosophy I have adopted, which pervades every aspect of my practice, is to educate patients, not to sell surgery. I stress this concept to my entire staff and insist that every question is to be taken seriously and that every patient is to be treated with respect. A patient comes to me with specific problems that may or may not have a solution. I carry out my duty as a surgeon, to inform the patient of the options, the expected results, and I make a special effort to stress the potential risks and complications. Each patient is offered the opportunity to inspect my before and after photographs. I make it a liberal policy to offer to my prospective patients, contact with many of my past patients so that they may privately and openly discuss their feelings about their surgery. It is often helpful to know the experiences prior patients had with myself and my staff from initial consultation through recovery. Finally, I emphasize that what they are contemplating is elective surgery and their decision should not be made hastily. Rarely does a patient decide to have surgery on the initial consultation. I do not condone and will not tolerate high pressure sales tactics in my practice.

Should a patient present or develop a problem that is beyond my expertise, I have no hesitation to refer him/her to another surgeon with greater experience with that condition. Once a patient has undergone surgery, they are followed frequently, giving each patient ample opportunity to discuss the results and address any concerns.

Finally, I believe that, like the surgeon doing the operation, the facility in which he operates, should also meet a minimum standard. In my outpatient facility, I have set the policy that there shall be duplicates of all essential equipment. In an outpatient setting, equipment failure is not acceptable. I have developed a very strong opinion that if surgery is to be performed in an outpatient setting, the facility should conform to some established external standard. As a result, over the past six months, I have undertaken the arduous task of preparing my facility for inspection and licensing by the Maryland State Department of Health and Mental Hygiene. This preparation will be in compliance with the Life Safety Code established by the National Fire Protection Association (NFPA 101). This standard has been adopted by the Occupational Safety and Health Administration (OSHA) and the Joint Counsel for the Accreditation of Hospitals (JCAH). I hope that by complying with these rigorous guidelines, I can ensure that my patients receive the highest quality of care. I expect to have this accomplished within the next six months.

With this background in mind, I would like to render an opinion of some the issues brought forth by the Subcommittee.

The qualifications of a surgeon to perform a specific cosmetic procedure is difficult for the patient to assess. Certainly, a plastic surgeon who has never performed a cosmetic rhinoplasty should not be considered adequately trained, even though his board certification states that he is. And a surgeon who performs a operation incorrectly 100 times cannot be considered qualified. Similar examples apply to all specialties. So how does a prospective patient evaluate a surgeon's abilities? Most patients seeking cosmetic surgery are referred to a surgeon by one of his prior patients. This type of referral has the inherent advantage of being able to inspect the doctor's work prior to seeking the surgery. This, of course, does not guarantee the success of any surgery as unexpected complications may occur even in the the most meticulously performed operation. Today, however, there is an increasing number of patients seeking surgery without benefit of knowing someone who has had cosmetic surgery. I believe that each patient should, at a minimum, be allowed to inspect before and after photographic results and whenever possible, be allowed to communicate with the surgeon's prior patients. The patients themselves are as qualified to judge of the surgeon's results as the surgeons. I feel strongly that the information patients exchange concerning the process of going through the procedure, is invaluable and I make it a liberal policy to offer this type of interaction, if desired. I have dozens of patients who are willing to talk to other prospective patients only because they were given a similar opportunity prior to their surgery. It is the surgeon who refuses to show his results that should be avoided.

I am pleased to say that most patients I encounter in my area are provided with adequate information concerning the potential risks of cosmetic surgery. It is not uncommon for my prospective patients to have seen at least one if not several other surgeons in consultation. Most describe a surprisingly uniform knowledge base between surgeons and that most risks and complications are outlined for the patient.

Finally, I would like to briefly address the issue of advertising as it applies to my practice. As you are aware, the use of advertisements in the medical profession is currently an accepted way to attract new patients. Some may feel, however, that despite its acceptance, advertising of medical procedures suggests questionable judgement at best, while at worst, in the case of deceptive advertising, may indicate unethical behavior. Though I cannot comment on the actions of others in my field, I can say from my personal perspective, the decision to advertise reflects a very practical need; that is, to let prospective patients know I exist. As a young surgeon with a new practice, I do not have the luxury of a large patient base for referrals. As a result, I chose advertising as a way to announce to the public, my surgical practice is open for business. I advertise in print and on radio. I feel my ads are accurate and informative with educational value. They simply describe cosmetic procedures and encourage interested patients to call for a consultation.

In closing, I share the Subcommittee's commitment to excellence. I feel it the responsibility of each practitioner to bring him/herself up to the current standard of care by regularly attending educational seminars and meetings. Post-graduate education in this rapidly changing field, is an absolute necessity. Throughout my career, I will seek additional training on an ongoing basis, enhancing my skills so that I can continue to provide quality care. It is my sincere wish that my testimony will be of value to the Subcommittee in its worthwhile task of assessing and improving the safety and quality of cosmetic surgery services rendered to the public. I would like to thank the Subcommittee for this opportunity to testify.

FACIAL
PLASTIC
SURGERY

TESTIMONY OF FRANK M. KAMER, M.D.

On behalf of the American Academy of Facial Plastic and Reconstructive Surgery, let me say how much we appreciate the Subcommittee's interest in the challenges facing consumers in their efforts to obtain the best facial plastic surgery.

The Academy is an interdisciplinary society that attempts to further education of those surgeons from various specialties performing facial plastic surgery.

At the outset, it is important to understand that a number of surgical specialties overlap in performing facial plastic surgery. Overlaps are common in surgery. The patient requiring hand surgery, for instance, can have that surgery performd by an orthopaedic surgeon, a general surgeon, or a general plastic surgeon. (A general plastic surgeon is one who performs plastic surgery of the entire body; you have heard from several general plastic surgeons this morning.) In the abdominal region, general surgeons, gynecologists, and general plastic surgeons all perform plastic surgery procedures. Plastic surgery of the eye is performed by ophthalmologists, otolaryngologists/head-and-neck surgeons, and general plastic surgeons.

Our Academy consists of more than 3000 surgeons from various specialties who wish to further the science of facial plastic surgery. The principal specialties addressing facial plastic surgery are otolaryngology/head-and-neck surgery, general plastic

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surgery, ophthalmology and dermatology, all of which address the soft and bony tissues of the head and neck. All of those specialties have well-established and recognized training programs for training post-graduate physicians in accredited residency programs. The general plastic surgeons who are members of our Academy, for instance, spent some of their plastic surgery training on the head and neck. The otolaryngologists/head-and-neck surgeons who are Academy members spent all of their post-graduate training on the face, head, and neck. The training of those otolaryngologists/head-and-neck surgeons included extensive work in the plastic surgery of the face.

As the President of the American Academy of Facial Plastic and Reconstructive Surgery, I speak on behalf of the more than 3000 surgeons who make up our Academy. The Academy's by-laws require that Fellows of the Academy must have achieved board-certification in one of the several disciplines addressing facial plastic surgery which are recognized by the American Board of Medical Specialties and must have been elected Fellows of the American College of Surgeons. Fellows of our Academy must have demonstrated competence in facial plastic surgery.

Our Academy is a constituent specialty society of the American Medical Association and the American College of Surgeons.

The Academy celebrates its twenty-fifth anniversary this year.

The Academy addresses only surgery of the face, head, and neck. Our members have in common a special interest in surgery of that bodily region.

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We focus primary efforts in the Academy on education. Let me describe our educational programs at the various levels of medical training. Most of our programs address physicians who have already completed their medical educations and have obtained their medical degrees. In medical schools, however, we do provide assistance in teaching basic soft-tissue surgery.

After medical school, a physician looking toward a specialty will begin an internship and a residency in that field. Many physicians focusing on facial plastic surgery will undertake residency in otolaryngology/head-and-neck surgery. In that training, they learn how to perform surgery of the nose to preserve and improve breathing, how to perform reconstructive cancer surgery on the head and neck, and how to perform other complex surgery on the face, head and neck. The Academy's Educational Foundation assists residency training programs by providing course materials, videotapes, and visiting professors in facial plastic surgery. We also sponsor awards for the most outstanding scientific research by residents in the field of facial plastic surgery.

After residency, the Academy's Educational Foundation provides still further educational opportunities. Physicians who have completed medical school and internship and residency can apply for one-year fellowships that provide more special training in facial plastic surgery. The Academy's Foundation accepts a limited number of physicians for training with preceptors who have

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achieved preeminence in facial plastic surgery. The fellows in such advanced training programs must follow a prescribed curriculum, complete an advanced research project, and pass an examination. The Academy's Foundation provides loans to assist physicians in fellowship training.

Our Academy and its Educational Foundation also devotes substantial resources to continuing medical education. We sponsor a number of major courses each year to provide the latest information to physicians in practice. Those courses provide advanced information about treatment of cancers of the head and neck and education about developments in safe aesthetic surgery.

We also hold scientific meetings, where our members and other surgeons can exchange what they have learned about new ways to perform facial plastic surgery.

These post-graduate courses for practicing physicians are important. No good surgeon ever finishes his training. Many surgical techniques that have been developed in the last decade were not previously taught in any academic programs. When I was in medical school and in my internship and residency training, for instance, laser surgery was in its infancy. No one learned the technique in formal academic training programs. Surgeons in my generation who have learned laser surgery have by and large learned it at courses sponsored by scientific societies like the Academy.

Liposuction is another example. Only after a French gynecologist developed the technique for fat suction a decade or

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so ago did surgeons discover the benefits to the patient of the procedure. And it took a series of special courses to teach surgeons using other techniques the advantages for the patient of using liposuction. In facelift surgery, for instance, liposuction provides the patient a safer form of treatment than previous techniques, and the Academy and its Foundation have provided training in that new technique to surgeons.

To this point, I have described the work of the Academy from the physician's standpoint. All that is background to what is really important: the well-being of the patient, the consumer in our health-care system.

The Academy believes patients in facial plastic surgery should come first. Physicians's economic needs and desires should take a subordinate place to the needs of patients. The Academy's experience reveals that patients need two things for a high quality of facial plastic surgery: first, highly-trained specialty surgeons focusing on facial plastic surgery, and, second, a range of choices.

The first requirement is important. Patients needing facial plastic surgery should receive the highest quality of care from their surgeons. As I have indicated in these remarks, the Academy seeks to assist in developing highly-trained facial plastic surgeons. By emphasizing and encouraging advanced training, the Academy attempts to train specialty surgeons focusing on the face, head and neck. The Academy believes the best training for facial

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plastic surgery is the most specialized training, and training focusing on the head and neck provides the most highly specialized training currently available.

The second requirement for high-quality patient care is equally important. The patient deserves choices in the marketplace. Without choices, the patient lacks consumer power. Our system of health-care gives the consumer power when he has choices in the face of exhorbitant fees or poor service. Without choices, the consumer is powerless.

The next several speakers will address those two requirements for high quality facial plastic surgery oriented to the consumer's interests: a high quality of training and the presence of choices in the marketplace.

Dr. Ted Cook, our next witness, is secretary and president-elect of the Academy. Dr. Cook is on the faculty of the University medical school in Portland, Oregon, where he focuses on the teaching of facial plastic and reconstructive surgery.

After Dr. Cook, we understand the Subcommittee wishes to hear from Dr. Simons, a former president of the Academy, who is in private practice in Miami. Dr. Simons will address the issue of directory listings and advertising.

After Dr. Simons, we understand you wish to hear from Dr. McCollough, another former president of the Academy, who will address the problems created for the consumer by anticompetitive conduct that has the effect of limiting the consumer's choices in the marketplace.

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SUPPLEMENTAL TESTIMONY OF
FRANK M. KAMER, M.D.

April 13, 1989

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Washington, D.C. 20005
202/842-4500

SUPPLEMENTAL TESTIMONY OF FRANK M. KAMER, M.D.

On behalf of the American Academy of Facial Plastic and Reconstructive Surgery, I'd like to thank you for allowing us to testify before your subcommittee on April 4.

As you announced at the hearing, the witnesses may supplement their testimony. I therefore request that this letter be made part of the permanent, written record of the April 4, 1989 hearing before the Subcommittee on Regulation, Business Opportunities, and Energy of the House Small Business Committee.

At the outset, it may be helpful to remind the Subcommittee which of the groups I represent among the numerous groups that testified at the hearing.

Our organization is the American Academy of Facial Plastic and Reconstructive Surgery. Our members specialize in facial plastic surgery. We are a constituent specialty society of both the American Medical Association and the American College of Surgeons. Our fellows are board-certified by one or more recognized boards of the American Board of Medical Specialties. As you recognized at the hearing, our group provides the most intense and lengthy training in head and neck surgery, and we are subspecialists in facial plastic surgery.

Following my oral testimony you asked me whether I believed the hearing was sensational or exploitive and lacked substance. Your inquiry was based on a headline and a few key words, contained in a two-page news release that was not before me at the time. Based on the way your question was phrased, I answered no. Subsequently, I obtained and reviewed a copy of the release. As written, I agree with the statement that "trooping out patients to testify about bad cosmetic surgery before a House subcommittee smacks of exploitation and sensationalism, [since s]uch tactics suggest that cosmetic surgery is universally unsafe and that doctors with expertise in this field are unconcerned about the patient's well-being...."

It is my understanding that on numerous occasions prior to the April 4 hearing, our Academy contacted your office and expressed its concern about bringing patients into congressional hearings.

None of the "bad case" patients presented, of course, had received facial plastic surgery, which is the focus of our Academy. And none had received surgery by any of our members.

That does not mitigate our concern, however, about the effect of such hearings. We said at the hearing, and we believe today, that no single surgical specialty holds a monopoly on good or bad results. For every bad result, you will find thousands of individuals whose lives have been enhanced because of plastic surgery. To highlight only bad cases may make good headlines, but it may be detrimental to the emotional well-being of the patient testifying, and it tends to develop a misperception that is damaging to the reputation of many highly-trained, highly-skilled surgeons.

We are at work now gathering the data you requested, and we shall have it to you shortly; however I wanted to "set the record straight" on this issue right away.

FACIAL
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TESTIMONY OF TED A. COOK, M.D.

Thank you for inviting me to testify before the Subcommittee on the subject of patient protection. As a constituent of Congressman Wyden, and as a full-time surgeon and a faculty member at the University medical school in Portland, I am delighted to be able to share my thoughts with you.

Dr. Kamer has stated the basic philosophy of our American Academy of Facial Plastic and Reconstructive Surgery. Consumers of facial plastic surgery need two things: highly-trained surgeons and a range of choices among surgeons. We in the Academy are dedicated to both goals.

Let me first address board certification. Members of our Academy are board-certified in at least one of the disciplines that address facial plastic surgery. Some are board-certified in more than one. Those boards are recognized by the American Board of Medical Specialties.

My own board-certification is in otolaryngology. The American Board of Otolaryngology examines physicians for competence in the various aspects of head and neck surgery, including facial plastic surgery. Before a physician takes the examination in otolaryngology, he or she must have completed an internship and a residency training program in the field.

As a full-time faculty member in one otolaryngology residency training program, I am familiar first-hand with the way those

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programs teach facial plastic surgery. After obtaining his M.D. degree in medical school, the physician takes a year or more of internship and general surgery training. Then he applies for a residency in otolaryngology. If he is accepted, the resident physician in otolaryngology focuses his training on the anatomy and function of the head and neck. He learns surgical techniques to improve breathing through the nose and to improve the appearance of the nose at the same time. He learns to perform surgical procedures where parts of the skin are moved from one part of the body to the face or neck. He learns to reconstruct faces mangled in car wrecks. He learns to remove tumors of the head, throat, and neck and how to reconstruct the tissues to preserve appearance. He learns to correct congenital defects, both functional and cosmetic. He learns to perform a parotidectomy, where the parotid gland is removed from deep in the neck.

And the otolaryngology resident learns to perform procedures that improve appearance. I just mentioned a parotidectomy. In that operation, the otolaryngologist performs an incision and elevates a skin flap in much the same way that he does in performing a facelift. Actually, the parotidectomy is a more complex operation than the facelift, because the parotidectomy must avoid damage to the nerve that runs through the parotid gland.

The otolaryngology resident also learns surgery of the eyelids. Because of their special characteristics, eyelids offer

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excellent tissue for grafts of various types. The otolaryngology resident becomes familiar with those eyelid tissues and learns to perform blephroplasties on those tissues. In a blephroplasty, the surgeon improves the patient's appearance by correcting droopy eyelids.

It is important for this Subcommittee to understand that facial plastic surgery to improve appearance is a worthy and important goal. In many cases, the surgery corrects a deformity such as a cleft lip or palate that existed at birth. In other cases, the patient needs facial plastic surgery to correct the results of a car crash where the patient's face went through the windshield. Often, the facial plastic surgery accompanies a necessary operaton to improve breathing through the nose.

In other cases, the facial plastic surgery improves the patient's normal appearance and gives the patient enhanced self-esteem and earning capability. Many jobs in today's beauty-conscious society require physical attractiveness. A newscaster, for instance, must "look the part," at least according to the people who hire newscasters. A person trying to get ahead in a profession like that looks at facial plastic surgery to improve his appearance as an economic investment in his career. The same is true of a number of professionals, including actors, models, and executives in certain industries.

Other patients do not need facial plastic surgery for their jobs but want the enhanced self-esteem that comes with looking

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good and receiving compliments on one's appearance.

Whether facial plastic surgery corrects problems or improves appearance or both, it is a worthy and important part of medicine.

Otolaryngology residency programs teach both the functional and aesthetic aspects of facial plastic surgery. And those otolaryngology residents train intensively in such procedures. Although I am not aware of any scientific study of the procedures taught in various residency programs, the straw-polls I have seen have indicated that otolaryngology residents perform more facial plastic surgery procedures in their residency training programs than do general plastic surgeons.

This is certainly the case at our University in Oregon, where in 1988, 734 facial plastic and reconstructive surgery cases were done in the department of Otolaryngology/Head-and-Neck Surgery. In contrast, only 98 such cases were done by the General Plastic Surgeons. (That is not an indictment of general plastic surgeons, who must necessarily spend a substantial part of their training on other parts of the body; a surgeon who must become proficient in surgery of the foot, hand, abdomen, breast, buttocks, and thighs cannot be expected to focus just on the face, head, and neck. It is, however, an affirmation of the extent of training in facial plastic and reconstructive surgery provided to residents in otolaryngology/head-and-neck surgery training programs throughout the country.)

Once he has completed his otolaryngology residency program, the otolaryngologist sits for his board-examination by the

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American Board of Otolaryngology. That examination focuses heavily on plastic surgery of the head and neck.

When the otolaryngologist completes his residency training program and his examination, he may wish to take a one-year fellowship in facial plastic surgery through the Education Foundation. That fellowship requires research, intensive hands-on experience in full-time facial plastic surgery, constant exposure to all aspects of care of the patient who has had facial plastic and reconstructive surgery, and still another examination.

Thirteen to fifteen years after graduating from high school, the otolaryngologist/head-and-neck surgeon is ready to begin his practice.

That practice may be in a hospital. Many otolaryngologists perform the majority of their surgery in hospital operating rooms.

Other otolaryngologists perform the majority of their surgery in ambulatory surgery centers. Ambulatory surgery, or surgery outside the hospital, offers the patient several important advantages. The first is cost. Whether the surgery is required to correct a defect or is desired to improve appearance, the patient and his insurance company deserve the benefit of lower costs that accompany ambulatory surgery.

A second advantage of ambulatory surgery is safety. Despite the best possible efforts, hospitals contain germs and other ogranisms that sick people bring in. Unavoidably, a certain percentage of patients that have surgery in even very good

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hospitals develop infections. Such infections also occur in ambulatory surgery centers, but more rarely. That is because such ambulatory surgery centers treat fewer sick people and have less of a chance to harbor infection-causing germs.

A third advantage to ambulatory surgery is better toleration by the patient. Surgeons and nurses involved in this type of surgery have noted and documented that patients tolerate ambulatory surgery much better than in-patient surgery in a hospital. They require much less sedation and thus have a higher margin of safety. Patients enjoy shorter recovery times and require less post-operative pain medication. Patients who have had the same procedure performed in both settings inevitably prefer strongly the ambulatory surgery experience.

The Subcommittee has expressed a special interest in the equipment present in an ambulatory surgery facility. We have arranged for such equipment to be here today, and I'd like to explain it to you.

[Demonstration of Equipment.]

The Academy believes facial plastic surgery is safe and economical in ambulatory surgery centers. The training in otolaryngology and the equipment almost universally available make it safe.

But all the great training and all the great equipment in the world will not do the patient any good unless the patient can find out about the surgeon and his facility. That is where the second important ingredient of quality care comes in: the availability of choices for the consumer. The Academy believes that consumers deserve the power in the marketplace that comes from knowing there is an alternative and being able to "vote with their feet" if the surgeon tries to charge too much or to provide substandard service.

Dr. Simons and Dr. McCollough will offer you their thoughts on the ways the consumer can obtain those choices and the way some physicians have attempted to deny the consumer those choices.

# # #

THE OREGON
HEALTH SCIENCES UNIVERSITY
3181 S.W. Sam Jackson Park Road, Portland, Oregon 97201

April 10, 1989

The Honorable Ron Wyden
Room 2452
Rayburn House Office Building
Washington, DC 20515

Dear Representative Wyden:

I am writing to thank you for the privilige of appearing before your subcommittee this past week. It was at once both an enlightening experience and a rewarding one to be able to participate in a hearing which was aimed at solving a significant problem in an honorable way.

I would reiterate to you that I do share your concern with respect to rapid growth of oftentimes misleading advertising in the field of cosmetic surgery. Similarly, I do share your concerns with respect to protecting the consumer public from physicians who are less than optimally trained to do the procedures they purport to do.

I have enjoyed over the past two to three months meeting and getting to know your staff investigators on the subject. Both Mr. Papineau and Ms. Murphy have done a superb job in educating themselves as to the background of this ongoing "medical industry." It is my personal belief that they have been fair and forthwright in their investigation and in their perceptions of the problems. On the other hand I am, however, as I explained repeatedly to both of them distressed that it was necessary to focus the hearing on blatantly emotional testimony.

I do wish to point out to you one aspect of the false and misleading advertising which I feel you must be aware of. In Portland, and indeed in Oregon in general, the only false and deceiving advertising with respect to cosmetic surgery of any form is the organized public relations effort by the American Society of Plastic and Reconstructive Surgery to purport that their Medical Board, The American Board of Plastic and Reconstructive Surgery, is the only Board which certifies its examinees in the area of plastic and reconstructive surgery. I hope that we were able to demonstrate to your Subcommittee that the American Board of Otolaryngology similarly certifies its examinees in the area of facial plastic and reconstructive surgery. Furthermore, the American Academy of Facial Plastic and Reconstructive Surgery has, for 25 years, provided literally thousands of forums of excellent education in facial plastic and reconstructive surgery.

Schools:
Schools of Dentistry, Medicine, Nursing

Clinical Facilities:
University Hospital
Doernbecher Memorial Hospital for Children
Crippled Children's Division
Outpatient Clinics

Special Research Division:
Vollum Institute for
Advanced Biomedical Research

The Honorable Ron Wyden
April 10, 1989
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I would therefore hope and trust that as you continue in your efforts to provide some form of direction for truthful advertising in cosmetic surgery that you provide help in halting this well organized and well funded deceitful advertising campaign on the part of the American Society of Plastic and Reconstructive Surgeons.

Thank you again for the privilege of appearing before your Subcommittee and for allowing me to participate in this ongoing dialogue.

Sincerely yours,

Ted A. Cook, M.D., F.A.C.S.
Chief, Division of Facial Plastic
and Reconstructive Surgery
President Elect, American Academy of Facial
Plastic and Reconstructive Surgery

TC/vr

cc: The Honorable Norman Sisisky
The Honorable William S. Broomfield
The Honorable Melton Hancock

enc.

SUPPLEMENTAL TESTIMONY OF TED A. COOK, M.D.

I am submitting this Supplemental Testimony pursuant to the Subcommittee's agreement that the Record would be held open for ten days, and I ask that this Supplemental Testimony be made part of the Record.

Our American Academy of Facial Plastic and Reconstructive Surgery is a constituent specialty society of the American Medical Association and the American College of Surgeons. Fellows in the Academy are board-certified by one or more ABMS certifying boards and specialize in facial plastic surgery.

After the Hearing, I reviewed the Subcommittee's "Press Alert" and "Press Release," which are attached as part of this Testimony. The Academy is deeply distressed at the way in which the Subcommittee's press release appear to be intentionally or unintentionally advancing the agenda of one of the specialty groups that is involved in the "turf battle," for cosmetic surgery. It is the fondest hope of every large business that some legislator or government administrator will regulate away troublesome competition by small business. Eliminating disclosure of legitimate board-certification in listings by competitors (or confining such disclosure to indecipherable Greek names) has long been a goal of one of the specialties involved. We also could not avoid noticing that the agenda of the Hearing and the questioning seemed calculated to provide maximum favorable media coverage to that specialty's proposals. Staff documents seem also to reflect very substantial attention to the general plastic surgeons' goals.

We believe this is too serious an issue to be addressed through a "war of Press Releases." For our part, we shall attempt restraint. We hope the Subcommittee will also attempt some restraint in its issuance of press releases and other documents that choose sides in a medical turf battle instead of focusing on the central issues of patient care.

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AND RECONSTRUCTIVE SURGERY, INC.

[illegible]

April 10, 1989

The Honorable Ron Wyden
Room 2452
Rayburn House Office Building
Washington, DC 20515

Dear Representative Wyden:

I am writing to provide you with answers to the specific questions that you directed to those of us appearing on behalf of the AAFPRS during our testimony at your Subcommittee hearing last week.

You inquired as to the number of complaints and/or grievances filed against our Full Fellows. I wish to point out to you that there is a distinct difference in our Academy between Junior Members, Members, and Full Fellows. The Junior Members are those members who are in training and are not yet Board Certified. Members are in general Board Certified but have not yet been in practice sufficiently long to be Fellows of the American College of Surgeons. Full Fellows are Board Certified, are Fellows of the American College of Surgeons or its equivalent, and have been through a full and elaborate investigation by the Credentials Committee of the Academy. The Peer Review Committee of our Academy is composed of all Past Presidents of the Academy itself. There has been only one Full Fellow who has been dropped from the membership roles of the Academy of Facial Plastic Surgery in the past 10 years. We have no records extending back from that time. There have been no fully documented charges filed against any other Full Fellow of the Academy in that time period.

You asked for the Academy policy statement on advertising. I enclose a copy of our advertising policy and of the Followship Pledge which all Full Fellows take on their induction as Full Fellows in the Academy. You will note that the Fellowship Pledge does require that the Full Fellow adhere to the advertising policy of the Academy.

Lastly, you inquired as to how many of our members were performing outpatient surgery and what percentage of the outpatient facilities are certified and by what certification organization. We have no specific survey of our membership which indicates the precise number of surgeons operating full-time or part-time in an outpatient operative setting. Our last general survey to this effect indicated that approximately 80% of our members performed some portion

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The AAFPRS was a founding member of the AAAHC and strongly supports certification of all outpatient operative facilities. Three of our fellows, including myself, operate in outpatient operative facilities in the State of Oregon and in all three instances the outpatient facilities are certified.

I hope and trust that the above responses are adequate to the questions you posed. Thank you for the opportunity to respond to your questions.

Sincerely yours,

Ted A. Cook, M.D., F.A.C.S.
Secretary, AAFPRS
President Elect, AAFPRS

TC/vr

cc: The Honorable William S. Broomfield
The Honorable Norman Sisisky
The Honorable Melton Hancock

enc.

ETHICAL ADVERTISING CODE: FC

Advertising is defined as a form of communication designed to inform the general public about the availability, nature or process of products and services.

The following are examples of the type of useful information that could be included in ethical advertising. The list is illustrative. It should not be interpreted as excluding other relevant information consistent with the ethical guidelines established herein.

1. Physician specialty;
2. Specialty residency, fellowships, and professional society memberships;
3. Specialty board certification;
4. Hospitals to which physician admits patients;
5. Office hours and after-hours coverage;
6. Appointment requirements;
7. Office location, telephone, and conveniences, e.g., proximity of public transportation, parking facilities, ramp, elevator, wheelchair;
8. Description of services, e.g., performance in office of x-rays and other diagnostic tests, prescription of birth control devices, etc.;
9. Ranges of fees for specific services and tests;
10. Acceptance of Medicare and Medicaid patients;
11. Acceptance of credit cards; and
12. Lanuages spoken.

Information That May Be Misleading

Some physicians who wish to advertise may unintentionally mislead the public by using statements that can be misconstrued. A few others may attempt to attract patients through advertising that is deliberately false and misleading. The Academy asserts that such advertising is not in the public interest and constitutes unprofessional conduct.

Members, therefore, need to understand what constitutes false, fraudulent, deceptive or misleading advertising. It may be so considered when a statement or claim:

1. Contains a misrepresentation of fact or omits a material fact necessary to prevent deception or misrepresentation.

2. Contains a picture or facsimile for the purpose of promoting relief or recovery unobtainable by the average patient by the methods advertised.

3. Contains a testimonial pertaining to the quality or efficacy of medical care or services that does not represent the typical experience of other patients.

4. Is intended or is likely to create false or unjustified expectations of favorable results.

5. Contains a claim that the physician possesses skills or provides services superior to those of other physicians with similar or equivalent training, unless such claims can be factually substantiated.

6. Takes improper advantage of a person's fears, vanity, anxiety or similar emotions.

7. Contains a claim that is likely to deceive or mislead the average member of the audience to whom it is directed.

8. Contains a false or misleading prediction or implication that a satisfactory result or cure will result from the performance of professional services.

9. States or implies that a physician is a certified specialist unless he is certified by a board recognized by the American Board of Medical Specialties.

10. Describes the availability of products or services which are not permitted by law.

11. Is likely to attract patients by the use of exaggerated claims.

12. Is not identified as a paid advertisement or solicitation unless it is apparent from the context that it is a paid announcement or advertisement.

13. Contains a statement of the fees charged for specific professional services without indicating whether additional fees may be incurred for related professional services which may also be required.

Adopted: July, 1981
Amended: June 2, 1985
Reviewed:

FELLOWSHIP PLEDGE **CODE: FA**

Each member of the Academy must adhere to and uphold the Fellowship Pledge.

FELLOWSHIP PLEDGE

I agree to abide by the Articles of Incorporation and Bylaws of the Academy and by such rules and regulations as may be enacted from time to time, and to advance and extend the ideals and principles of the Academy.

I pledge to pursue the practice of surgery with scientific honesty and to place the welfare of my patients above all else, to advance constantly in knowledge, and to render willing help and teaching to my colleagues in medicine and seek their counsel when in doubt as to my own judgment.

I agree to abide by the guidelines on advertising which are adopted by the Academy in order to promote legitimate and ethical advertising of physicians' services and to avoid the occasion of unprofessional conduct through false or misleading advertising.

I declare that I will not practice the division of fees, either directly or indirectly, and that I will make my fees commensurate with the services rendered and with the patient's rights.

Finally, I declare that on revocation or resignation of membership I shall return my membership certificate to the Academy.

Reference: Articles VII, Section 2, Bylaws
Adopted: 1964
Amended: October 16, 1982
Reviewed: June 2, 1985

FACIAL
PLASTIC
SURGERY™

AMERICAN ACADEMY OF FACIAL PLASTIC
AND RECONSTRUCTIVE SURGERY, INC.

[illegible]

March 10, 1989

Representative Ron Wyden, Chairman
Subcommittee on Regulation and
Business Opportunities
B-363 Rayburn Building
Washington, DC 20515

Dear Rep. Wyden:

At your request, I am happy to enclose a copy of the Academy's position paper on accreditation for ambulatory health care facilities.

I've enjoyed working with Frank Papineau on this hearing and look forward to testifying in April.

Please let me or the Academy's Executive Vice President Lee VanBremen know if we can be of assistance in any other way.

Sincerely,

Ted A. Cook, M.D.
Secretary

Enclosure: Position of AAFPRS on Accreditation for Ambulatory Healthcare Facilities

kjl

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POSITION OF AMERICAN ACADEMY OF FACIAL PLASTIC AND RECONSTRUCTIVE SURGERY ON ACCREDITATION FOR AMBULATORY HEALTHCARE FACILITIES

The American Academy of Facial Plastic and Reconstructive Surgery is a national specialty society of board-certified surgeons performing facial plastic surgery. The Academy is a constituent specialty society of the American Medical Association. The Academy's bylaws require that its Fellows be Fellows of the American College of Surgeons and certified by one of the boards recognized by the American Board of Medical Specialties.

The Academy believes that the following principles should guide accreditation of ambulatory healthcare facilities:

The Lodestar: Patient/Consumer Welfare

The Academy believes that patient and consumer welfare should form the lodestar of decisions about ambulatory healthcare facilities. Such patient and consumer welfare requires two things: (1) high professional standards and (2) choices in the marketplace among qualified surgeons. High standards benefit patient/consumers by assuring them that their surgeons and those surgeons' facilities will be safe. Choices in the marketplace among qualified surgeons benefit patient/consumers by saving them from the tyranny of monopolistic pricing.

Securing High Professional Standards

The Academy has attached hereto its policy on Credentialing Ambulatory Healthcare Facilities. The essentials of a standard setting procedure include adherence to medical guidelines from an impartial facility certifying organization, such as the Accreditation Association for Ambulatory Healthcare. The Academy believes a multi-disciplinary accreditation organization is superior to one that is controlled by a single specialty and that therefore is more susceptible to incestuous influences. Similarly, physicians should arrange for peer review of their facilities on a systematized basis (which is one of the criteria for accreditation by the Accreditation Association for Ambulatory Healthcare). Physicians operating ambulatory healthcare facilities should also receive continuing medical education, particularly in such new fields as laser surgery and liposuction, in which very few physicians received formal training in their initial residencies.

Securing Choices for Patient/Consumers Among Qualified Surgeons

Consumers also deserve free choices among qualified surgeons, unencumbered by doctor-monopolies. In the medical marketplace, as in the marketplace generally, consumers benefit by being able to cast their economic ballots among competing sellers. Healthy competition in the marketplace gives consumers choices that promote fair prices and a high quality of treatment. A consumer can "vote with his feet" if he has a choice. But, if the entrenched incumbent surgeon in a town has managed to keep out competition, the consumer has no choice; the patient/consumer must pay whatever price the monopoly-surgery demands and endure whatever service the monopoly-surgeon chooses to provide.

Several principles foster viable choices for the patient/consumer:

First, patient/consumer (and legislative decision-makers) should be suspicious of claims that only one surgical specialty can perform a procedure such as facial plastic surgery. In truth, the American Medical Association, the American Board of Medical Specialties and numberous other organizations unanimously state that surgeons from different specialties may possess equal competence in certain procedures. The modern board-certified otolaryngologist, for instance, likely received more training in surgery of the head and neck, including plastic and reconstructive surgery of that bodily region, than the general plastic surgeon, who necessarily devoted much of his training to abdominal surgery, hand surgery, foot surgery, etc. A physician claiming that his specialty desire a monopoly on competence is really saying that his specialty desires a monopoly on profits.

Second, accreditation of ambulatory healthcare facilities should be separated from the credentialing of physicians for hospital staff-privileges. Hospital staff-privilege decisions are notoriously petty and political. Often the decision to exclude a physician from a hospital staff is based on factors having nothing to do with the physician's competence. A hospital may, for instance, decide that it doesn't need another physician in a particular specialty, or that a physician's ambulatory healthcare facility competes with the hospital's own emergency room.

Often a new, young surgeon in a town may find his hospital privileges blocked by older incumbent surgeons with established practices who are afraid of the new competition. The incumbent surgeons further seek to restrict the new, young surgeon's ambulatory surgery by the excuse that the new surgeon doesn't have hospital surgical privileges for those procedures to be done in his ambulatory surgery unit. Again, "where you stand depends on where you sit," and decision-makers should be suspicious of entrenched specialists who urge the argument that accreditation of ambulatory healthcare facilities should be solely based on hospital staff privileges. (Accreditation of such ambulatory of such ambulatory facilities should, however, require that the facility have arrangements and procedures for instantaneous treatment of outpatient complications at a nearby hospital, and such arrangements are required by the Accreditation Association for Ambulatory Healthcare.) The Academy reaffirms its commitment to certification of surgical credentials through board certification and fellowship in the College of Surgeons.

Third, the market for healthcare services functions best in a deregulated environment. Governmental regulation carries the potential for substantial expenditure of tax dollars and increased prices for patient/consumers. It is the fondest dream of every monopolist that his legislature will outlaw future competition—particularly through some sort of standard-setting procedure. But government regulation of small businesses seldom benefits consumers or the majority of small businesses themselves. As the chairman of the FTC has pointed out, the unregulated free enterprise system doesn't have to work perfectly to work better than government regulation. There is no substantial evidence that government regulation would do any better in accrediting ambulatory healthcare facilities than organized medicine.

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TESTIMONY OF ROBERT L. SIMONS, M.D.

Thank you for inviting me to testify before your subcommittee today. I understand you want me to talk about advertising and listings in directories. As a facial plastic surgeon in private practice in Miami for more than sixteen years, I have seen a number of disputes among physicians about listings in directories and an increasing amount of advertising.

The American Academy of Facial Plastic and Reconstructive Surgery neither encourages nor discourages advertising. The Academy has a strong ethical policy against misleading advertising. It does note, however, that informative advertising and directory listings can provide helpful information to the consumer that gives the consumer power in the marketplace.

First, let me address the subcommittee's question about whether deceptive advertising presents a serious problem in facial plastic surgery. (My remarks, of course, address only facial plastic surgery; our Academy does not address surgery of other bodily regions.)

The Academy does not believe there is any special problem of deceptive advertising in facial plastic surgery. Overly aggressive advertisers exist in every trade or profession. If you look hard enough, you can find overly aggressive ads in any industry, and

- more -

plastic surgery is no exception.[1]

The real test is whether consumers are being hurt. In all this argument about advertising in facial plastic surgery it is useful to ask "who is doing the complaining?" Is it consumers? No, we are unaware of a single consumer complaint to any state or federal agency about advertising for facial plastic surgery. The complaints come, by and large, from entrenched incumbent surgeons unhappy about new competitors.

We believe there is less deceptive advertising in facial plastic surgery than in most other professions and businesses.

Advertising and directory listings raise another more serious issue, however: consumer power in the marketplace. Let me begin by stating a basic truth: consumers benefit from having choices among qualified surgeons. Let's take the case of a patient--we'll call her Mary Jones, in a town in New York. Mary was in a car wreck last year. The emergency-room surgery unavoidably left scars on her face. She is looking for a facial plastic surgeon to make the scars less noticeable. She has to stay in her area, because she has small children at home.

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[1] The general plastic surgeon's national society, the ASPRS, agrees. In its November 1988 publication of Plastic Surgeon, (p. 9) the ASPRS printed an interview with its president noting the "misleading advertisements" of some general plastic surgeons:

> Q: One hears complaints about members who are advertising in a way that's seen as misleading or in poor taste. Should the Society take a stronger stand on member advertising?
>
> A: Dr. Reading: We have a very strong code of ethics concerning advertising, and we will continue to enforce it. Of course, "poor taste" is in the eye of the beholder, but false and misleading advertising is something else all together. We will pursue any violation of the code.

The ASPRS president also noted:

> It bothers me that a few.....members give us all a bad name by charging outlandish fees... and defrauding insurance companies.

Mary goes to her directory and finds only one surgeon listed under "plastic surgery." She goes to that surgeon: let's call him Dr. X. She has to wait almost an hour to see him, and Dr. X turns out to be insensitive and his staff rude. Dr. X quotes her a price that she considers too high. She does not feel comfortable with him. When she mentions another surgeon that she has heard of, Dr. X tells her that the other surgeon is not qualified. Dr. X tells her that the other surgeon was "trained in his garage" and has not received staff privileges for facial plastic surgery at the most prestigious hospital in the area. He pulls out an article in the local Sunday news magazine that quotes Dr. X as saying that the other surgeon is incompetent.

Mary still doesn't feel comfortable with Dr. X, and she still feels like his price is exhorbitant, but he has naturally scared her about the other surgeon.

What are Mary's choices? Can she "vote with her feet" the way she could if she didn't like the service or the prices in a normal consumer transaction? No, as a practical matter, she is stuck with Dr. X. She has no consumer power. She must pay what he demands and endure whatever rude treatment he chooses to provide.

- more -

Mary, like other consumers, needs choices to have power in the marketplace.

Dr. X can obtain power over consumers like Mary, if he is able to keep other qualified surgeons from being listed in the directory and if he prevents other qualified surgeons from providing useful information in advertisements. Dr. X increases his power if he is able tc deprive competing surgeons of staff privileges and if he is able to intimidate Mary by false disparagement of his competitors' being "trained in their garages."

Because of the potential for eliminating new competition and gaining power over the consumer, entrenched incumbent surgeons often resort to attempts to limit directory listings of competing surgeons. Such attempts take several forms. The most blatant is to attempt to exclude competing surgeons entirely from directory listings for certain procedures. For instance, Dr. X in our example, a general plastic surgeon, might try to get his local or state medical association to exclude all otolaryngologists/head-and-neck surgeons from yellow-page listings for plastic surgery. As Dr. Kamer and Dr. Cook have demonstrated in their testimony this morning, the modern otolaryngologist/head-and-neck surgeon is well-trained in plastic surgery of the head and neck. But Dr. X, the general plastic surgeon, knows that he will lose patients to competing surgeons if he allows those patients to find out about the competition.

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This is not an academic case. It happened in Miami, and it has happened in a number of other cities across the country. As Dr. McCollough will discuss in his testimony, anti-competitive actions by the general plastic surgeons sparked an investigation by the Federal Trade Commission in the 1970s. An FTC Staff Report noted numerous illegal but "successful efforts to restrict the listings of regional plastic surgeons in Florida, Washington State, Kentucky, Texas, Oregon, New York State, and Minneapolis."[2]

Dr. X, the general plastic surgeon, may try to keep his competitor out of the listings for "plastic surgery" by involving his local or state medical association or its board of ethics in the plan. If a highly trained and highly qualified otolaryngologist/head-and-neck surgeon lists his practice under "plastic surgery"--pointing out that his practice is limited to plastic surgery of the face, head, and neck--the otolaryngologist/head-and-neck surgeon may receive a summons to an ethics hearing and find an ethical sanction on his record for the rest of his professional practice.

If Dr. X, the general plastic surgeon, cannot keep his competing surgeons' listings out of the yellow-page listings

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[2] Federal Trade Commission Staff Report, "Recommendation that Complaint Issue Against the American Society of Plastic and Reconstructive Surgeons, Inc. for Violation of Section 5 of the Federal Trade Commission Act by Excluding Competitors; File No. 761-0055," pp. 43-44.

- more -

completely, he may try to limit their effectiveness as much as possible.

One popular approach is to "stick" the otolaryngologist/head-and-neck surgeon with the Greek name of his specialty and to keep him from using any meaningful English equivalents to provide useful information to consumers. The specialty of general plastic surgery, as a more recent addition to the ranks of specialties, has an English name. Through its political influence in the American Board of Medical Specialties, the American Board of Plastic Surgery has been able to prevent the American Board of Otolaryngology, from changing its name to add the English words "Head-and-Neck Surgery." The American Board of Plastic Surgery has even succeeded in preventing the American Board of Otolaryngology from listing on its certificate the areas covered by its examination, including "facial plastic surgery."

Thus, recent efforts to limit advertising have focused on requiring only the official name of the examining board to be used in advertising or directory listings. By "sticking" the otolaryngologist/head-and-neck surgeon with a Greek name incomprehensible to most prospective patients, the general plastic surgeon obtains a strong marketing advantage.

We have enlarged for the Committee's examination some advertisements by general plastic surgeons showing the use they attempt to make of their English name. The first advertisement includes the name of one of the general plastic surgeons who testified this morning. His advertisement implies, incorrectly, that his certifying board is "the only....recognized" board addressing plastic surgery.

The second advertisement bears the logo of the general plastic surgeons' national society, the ASPRS. The ad urges consumers to avoid unqualified plastic surgeons and go only to general plastic surgeons. By implication, the ad states that competing specialties are "potato-heads" who do not provide training in facial plastic surgery, which is not true.

The third example is a cartoon appended to an article by a general plastic surgeon in Arizona, who was arguing that only general plastic surgeons should be allowed to perform plastic surgery.

Such misleading advertising carries the potential to deceive the consumer into believing that only general plastic surgeons are trained or competent to perform facial plastic surgery.

The consumer deserves the opportunity to make informed choices. Attempts to limit those choices by limiting directory listings and advertising work against the consumer and should be rejected.

# # #

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SUPPLEMENTAL TESTIMONY OF
ROBERT L. SIMONS, M.D.

April 13, 1989

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SUPPLEMENTAL TESTIMONY OF ROBERT L. SIMONS, M.D.

I very much appreciated the opportunity to appear before your House Subcommittee last week. You will recall that I appeared on behalf of the American Academy of Facial Plastic and Reconstructive Surgery, an organization of board-certified specialty surgeons performing plastic surgery of the face, head and neck. It is regrettable that the Subcommittee found so little time to hear our Academy's views at 4:30 p.m. on the date of the Hearing - particularly after the much more extensive attention given earlier in the day to former patients and general plastic surgeons while media coverage was occurring.

Since returning to Miami, there are just a few observations I feel would be important to add to my testimony. As the Record is open for Supplemental Testimony, I ask that this further Testimony be received and made part of the Record.

Trends in Advertising and Professionalism

The proposition that plastic surgery has become increasingly popular among the public is certainly accurate. However, the suggestion at the Hearing that this growth was largely based on the slick, enticing advertisements of medical entrepreneurs is not true.

You questioned me about the "upbeat" nature of the advertising, and I do not believe time permitted me to give you a full answer to your query.

It is my belief that, certainly in the area of facial plastic surgery, it is the "upbeat" countenances, appearances and personalities of satisfied patients rather than the "hype" of advertisements that have created the large market for such surgery.

If the growing number of facial plastic surgery patients among neighbors, friends or relatives evidenced any significant degree of disfigurement or disillusionment, no amount of "Madison Avenue" marketing could keep that area of medicine alive.

Furthermore, in our specialty of facial plastic surgery, the increased numbers of satisfied patients do not reflect a meaningful presence of "charlatans" or "quacks," but rather a significant growth in the number of well-trained, highly qualified, sincerely motivated facial plastic surgeons.

In my editing of the forthcoming 25th Anniversary Book on the history of the American Academy of Facial Plastic and Reconstructive Surgery, I was continually impressed by the recurrent efforts and emphasis placed on education and proper training to provide the highest level of patient care.

I also feel it is important to share with you our Academy's experience with the public's reaction to medical advertising. The Academy's experience indicates that patients do not find advertisements for facial plastic surgery to be misleading or inappropriate. In fact, patients welcome informative advertisements and request more information in response to such advertisements about what the procedures involve, and where to go and to whom to go for such services.

It seems informative that the complaints for such advertisements do not seem to come from consumers. Indeed, we are unaware of any complaint by a consumer to any federal or state enforcement agency about any advertisement for facial plastic surgery. The complaints have all come from competing physicians. And those physicians are the entrenched, incumbent, established general plastic surgeons, for the most part.

One of the witnesses from among the general plastic surgeons bemoaned the large amount that - he said - a new, young surgeon must budget to establish his practice through public relations and marketing. (The witness was apparently describing his experience in general plastic surgery advertising.) The alternative is the course urged by all incumbent monopolists: keep out new competition by denying the public access to knowledge about the new entrants into the market.

Faced with a choice between eliminating truthful disclosures by a new, young competitor or curbing such disclosures at the behest of an incumbent monopolist, our free society has always favored the former course.

The FTC

In regard to this issue, I feel it is terribly important for your Subcommittee to consider the continued anti-competitive efforts of the general plastic surgeons. There is little question that their agenda is still to limit the choice of a consumer to surgeons certified by their Board of Plastic Surgery, despite the acknowledged qualifications of surgeons in other specialties.

Following Dr. Gorney's presentation at the hearing, a listener might be led to believe that we would not have encountered the unfortunate patients with surgical complications seen in the hearing room if only the Federal Trade Commission had not meddled into medical affairs back in the 1970s - and that the world would be a simpler and safer place if the general plastic surgeon were the only recognized provider of plastic surgery services.

However, the testimony from the patients that morning, as well as the large number of satisfied patients of highly specialized facial plastic surgeons, readily refute that argument. Rather than "bashing" the FTC, the Congress should be commending efforts of the FTC staff to prevent monopolistic tendencies and to provide the consumer with reasonable choices.

The ABMS

You asked some questions about membership in the American Board of Medical Specialties - a private corporation in Illinois, with which 23 medical boards are affiliated. The ABMS will likely agree that its members do not include all legitimate certifying boards. As medical knowledge expands, new areas of practice emerge, and new certifying boards come into existence. At any given time, several legitimate boards are emerging and eventually seek ABMS membership. The Washington Post reported on April 4, 1989 that two boards are currently seeking ABMS status. Other legitimate non-ABMS boards administer examinations in fields such as laser surgery and electromyography.

Inevitably, those emerging boards overlap with existing boards. (General plastic surgery, for instance, began as a combination of general surgeons, otolaryngologists/head-and-neck surgeons, and others.) And because ABMS policies effectively prohibit membership by more than one certifying board in a field, incumbent boards can "protect their turf" by seeking to prevent recognition of a competing new board.

It would be an extraordinary day in Congressional History if this Subcommittee were to urge a "balkanization" of medicine along the lines suggested by the general plastic surgeons. Enlightened Government has traditionally abhored monopolies and resisted enshrining "closed clubs."

If any "diploma mill" were to emerge, the FTC and every state government would presumably jump on it in an instant. But the Law does not start from the proposition that all doctors are crooked. The Law starts with the assumption that doctors are honest, and that they form honest, legitimate organizations. And a presumably honest board-certification provides useful information to consumers.

I thank you for considering these thoughts and wish you the very best in your deliberations in this very important matter. We hope your consideration of these issues will reflect a balanced consideration of the need to protect the consumer and to offer the consumer choices among trained and qualified surgeons. It is difficult for such a sober, thoughtful investigation to occur in the context of press releases and "sound bites" for television cameras.

We look forward to helping the Subcommittee with its studies in a balanced, scientific manner.

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TESTIMONY OF E. GAYLON McCOLLOUGH, M.D.

Like the other surgeons here today, I am honored to be before this subcommittee to present my perspective on the issues consumers face in facial plastic surgery.

In preparing my remarks I was reminded of the statement made by a former President of the United States. Andrew Jackson said, every monopoly and all exclusive privileges are granted at the expense of the public. I understand that your committee's charge is to protect small business from unfair trade practices and to safeguard the consumer's right of free choice in America's free enterprise system. The medical practice of plastic surgery qualifies as a business, albeit a unique business. Plastic surgery also qualifies as an art and a science. Since neither art nor science knows boundaries, it is ludicrous for any single group of individuals to claim exclusive rights to either. As a business, however, surgeons must refrain from unfair trade practices.

Dr. Kamer and Dr. Cook have described the qualifications of facial plastic surgeons. Dr. Simons has described the benefits consumers gain from having choices among qualified surgeons who perform facial plastic surgery. In particular, Dr. Simons has reviewed the problems faced by Mary Jones, the consumer in a town in New York who wished to have scar-revision performed to complement emergency surgery from a car wreck. She contacted the

- more -

only surgeon allowed to list in the yellow-pages directory under plastic surgery. The surgeon quoted her a fee she felt exhorbitant, and did not give her the attention she felt she deserved. He told her that other surgeons performing the identical procedure in her town were "trained in their garages," and that the most prestigious hospitals in town had denied hospital privileges to the competing surgeons.

Unfortunately, Mary's scenario occurs every day in this country. Through false disparagement and control of the information available to consumers, established general plastic surgeons exclude qualified facial plastic surgeons from offering choices to consumers like Mary.

This practice has gone on for many years. General plastic surgeons have spent tens of millions of dollars in public-relations and state lobbying campaigns attempting to exclude qualified facial plastic surgeons from the marketplace.

In the 1970s this activity had become so blatant that, as the authors of the plan had predicted, it attracted the attention of the staff of the Federal Trade Commission. After an exhaustive investigation, a staff report was prepared recommending a formal case. That report found, and I quote:

> Because of conspiracy, physicians who are board-certified in other medical specialties such as otolaryngology, ophthalmology, general surgery or orthopaedic surgery have been blocked from performing plastic surgery for which they are trained and competent. Moreover, the conspiracy deceives consumers about the qualifications of these physicians and forecloses consumers from freedom of choice among physicians.

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The general plastic surgeons hired a powerful Washington lawyer and launched an extensive campaign to kill the FTC case. One of the general plastic surgeons you heard earlier this morning led the campaign.

The FTC did not vote out the Complaint.[1] The general plastic surgeon you heard this morning received an engraved award from the general plastic surgeons that he now displays in the parlor of his office. That award congratulates him as the author of the victory in the case of "The Federal Government against Plastic Surgery." Also on his wall is a cartoon showing the Federal Trade Commission with a broken lance in its unsuccessful attack on the unfair practices by general plastic surgeons.

Although the FTC investigation fell short of its mark, it did expose many of the tactics general plastic surgeons use to restrict competition. In a sworn deposition, the general plastic surgeons' executive vice president admitted that he had developed a plan and distributed it to the leadership of the ASPRS for waging the guerilla war against competing doctors. In the words of that plan, the general plastic surgeons would apply what they called principles of "Fabian socialism" to fight a "cold war" designed to freeze out competition. In the words of that strategy, general plastic surgeons would wear a "political mask of constant negotiation" while really pursuing the "stalling technique."

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[1] We do not question the motives of the Federal Trade Commission, which has long stressed the importance of consumer choices in medical services. The FTC has stood, often alone, for the rights of consumers in their dealings with physicians. The ASPRS investigation arose in an era when some threatened non-appropriation of funds, and the FTC's decision not to launch a formal complaint reflected the institutional necessities of the time.

In the same year that "Cold War Strategy" was promulgated (1973), the general plastic surgeons sponsored and financed a patently groundless malpractice action against one of the most prominent otolaryngologists in the nation performing facial plastic surgery, Dr. Jack R. Anderson.

Dr. Anderson is a board-certified surgeon who is nationally respected for his work in facial plastic surgery. He has been a full clinical professor on the faculties of two major medical universities and has written two medical textbooks and more than 80 scientific articles.

In sworn testimony, Dr. Anderson's former patient has testified that, as a plaintiff, he would be performing a "national service" if he would help the general plastic surgeons get rid of "quacks" like Dr. Anderson and his "school" who were "trained in their garages." The general plastic surgeons stated they would pay all legal fees if the patient would allow them to bring the malpractice action in his name. The general plastic surgeons obtained the expert witnesses and directed the lawsuit. I was training in New Orleans at the time and witnessed the events I have just described. The jury found Dr. Anderson free of any malpractice.

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Two years later, the president of the general plastic surgeons' national society asked the author of the aforementioned Cold-War/Guerilla memorandum to develop a strategy for dealing with the competitive threat from other specialties who perform plastic surgery. In another document obtained by the Federal Trade Commission general plastic surgeons noted their historical ability "to have frustrated [other specialists'] efforts as long as we have." That document also recognized that "we [meaning the general plastic surgeons] have the power, ability and cohesiveness of our members to stall and frustrate the majority of [other specialists'] efforts to achieve national recognition from organized medical societies" and noted that these activities might bring about action from the Department of Justice.

Therefore, the general plastic surgeons' Cold War strategists suggested that their "plan must consist of a stalling mechanism."

That same year, general plastic surgeons in Arizona published an article entitled "Things Are Never What They Seem, Skim Milk Masquerades as Cream." The article attacked other specialists as unqualified pretenders, claiming that general plastic surgeons are "cream" and that other practitioners of plastic and cosmetic surgery are "skim milk."

Several years later the same article appeared almost verbatim in a publication 2000 miles east of Arizona in Georgia, with the same title. The Georgia article attacked Dr. Anderson personally. This is the same Dr. Anderson against whom general plastic

- more -

surgeons had promulgated the groundless malpractice suit in 1973. At the time the Georgia Skim Milk Article was published, however, Dr. Anderson was at the end of his career. He had earned a place annals of medical history and deserved respect. The Georgia "Skim Milk Article" attacked him as a quack who had formed bogus societies as a "smokescreen" to hide his purported lack of qualifications. Our Academy is recognized by the American Medical Association, the American College of Surgeons and many other prestigious medical organizations yet it was singled out for a special attack.

General plastic surgeons refused to publish a retraction, leaving both Dr. Anderson and the Academy no apparent choice but to ask the Courts for relief. The general plastic surgeons refused to settle. Their lawyer told the judge that "the jury cannot make us apologize."

After hearing all the facts, however, the jury returned a verdict for $1.5 million against the general plastic surgeons who had attempted to ruin Dr. Anderson's and the American Academy of Facial Plastic and Reconstructive Surgery's good names.

I was the Academy's designated representative for that trial, and have personally witnessed what I have just described. I have not revealed this to hold Dr. Anderson's trial up as an ideal way to resolve medical disputes. On the contrary, it has been a sad chapter in medical history.

I have described these events, however, to show the danger the American consumer faces from monopolists. When any single

- more -

specialty succeeds in excluding other qualified specialists from practicing their art, the consumer suffers. Healthy competition in the medical field forces all practitioners to do better work. When the consumer's choices are limited, he must pay more for services and endure whatever treatment the monopolists provide. Groundless malpractice actions, multi-million dollar disparagement campaigns, and limitations on directory listings hurt the consumer.

Those of us representing facial plastic surgeons are pleased to have the opportunity to address this distinguished committee. I have attempted to describe some of the guerilla warfare tactics an entrenched group of general plastic surgeons have conducted during their 20 year Cold War against competing surgeons. When each of you review the facts, I believe that you too will agree that there exists an attempt to monopolize the practice of cosmetic and plastic surgery and exclude competition.

If there is to be any legislation it ought to require that recipients of federal funds must not permit discrimination on the basis of race, sex, creed, or medical specialty. We ask you to recommend that federal funds not be provided to recipients who attempt to perpetuate anticonsumer monopolies.

# # #

FACIAL • PLASTIC • RECONSTRUCTIVE SURGEONS
E. Gaylon McCollough, MD, FACS
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COSMETIC AND RECONSTRUCTIVE SURGERY OF THE NOSE, FACE, BREASTS AND BODY

E. Gaylon McCollough, M.D.,
President and Founder

Board Certified Fellow
American Academy of
Facial Plastic and
Reconstructive Surgery, Inc.

Certified, 1975, ABO
Otolaryngology (Head
and Neck Surgery),
Member ABMS

Clinical Professor UAB
Medical Center, Dept. of
Surgery, Otolaryngology

American Academy of
Facial Plastic and
Reconstructive Surgery, Inc.
President 1986-87
Vice-President, 1985
Secretary, 1979-84
Graduate Fellow, 1973

American Association of
Cosmetic Surgeons, Inc.
President 1980-81

American Board of
Cosmetic Surgery,
Honorary Member

American College of
Surgeons, Fellow

American Medical
Association (Physician's
Recognition Award)

American Academy of
Otolaryngology—
Head and Neck
Surgery, Fellow

Alabama Society of
Otolaryngology—Head and
Neck Surgery, President
1985-86

Southern Medical
Association

Medical Association of the
State of Alabama

Jefferson County Medical
Society

National Council for the
Medicine, Dentistry and
Surgery of Appearance
Chairman 1987-88

. . .

*Registered Professional
Association (State of Alabama)

April 7, 1989

Congressman Ron Wyden
Committee on Small Business
House of Representatives
2361 Rayburn House Office Building
Washington, DC 20515

Dear Congressman Wyden:

Thank you for inviting me to the Subcommittee hearing on Cosmetic Surgery last Tuesday. You might remember during my testimony I stated that you, the other committee members, and your staff may have been mislead by the General Plastic Surgeons (ASPRS).

You heard from a witness for the General Plastic Surgeons that you should not pay any attention to "Cold War" plan drafted by an officer of his Society (ASPRS), because that plan had never been distributed to his Society's leadership (copy enclosed).

Pursuant to your agreement at the hearing on April 4, I offer one further addition to my testimony and, what I believe to be a reasonable solution to some of the problems raised.

First, I invite the Subcommittee's attention to the attached sworn testimony by the former officer of the ASPRS who authored the plan. You will see at page 516 of his testimony that the "Cold War" document was "prepared for the Board of Directors" and "distributed to the Board of Directors" of the ASPRS.

It is disappointing that the Subcommittee's hearing seemed primarily devoted to advancing the agenda of the ASPRS. For years the General Plastic Surgeons have attempted to further their cause through slick slide shows, "sound bites" and exploitation of dissatisfied patients. Such activites play well on television but add little to a sober, reasonable exploration of what is truly best for the consumer.

The Subcommittee should avoid taking sides in a "turf battle" and should focus instead on the mission of the Small Business Committee: to insure opportunities for businesses and choices for the consumer.

While the American Academy of Facial Plastic and Reconstructive Surgery agrees that surgeons performing plastic and cosmetic surgery should adhere to the highest possible standards, we disagree that any one group should be given exclusive privileges or allowed to conduct anti-competitive practices.

You and the Subcommittee have a unique opportunity to help solve some of the dilemmas which have been raised, but there is an alternative to legislation or new governmental regulations. A mandate from your committee to the American Medical Association, American College of Surgeons, and each of the Societies which appeared before your Subcommittee (along with the help of the Federal Trade Commission) could serve as a directive to allow the medical profession to solve the problem; then no new governmental regulations would be necessary.

Some of the advertising which is a concern to us, too, could have been generated by surgeons who were overreacting because entrenched surgeons were attempting to exclude them from the marketplace. For years General Plastic Surgeons have deceived the public claiming that no other specialists were qualified to perform plastic surgery. Such a statement is a clear example of false and deceptive advertising (see enclosed). The American Board of Otolaryngology's training programs and certification examination include plastic and reconstructive surgery of the head and neck. Like the American Board of Plastic Surgery, the American Board of Otolaryngology is a member of the American Board of Medical Specialites (ABMS). As technology and superspecialization emerge within the medical profession, however, new certifying boards to examine superspecialists are necessary.

Given the mandate and "clout" to do so, each Society and/or "board" could establish stronger peer review guidelines which could help put medical advertising in the proper perspective, establish stronger guidelines for outpatient surgical facilities and take steps designed to see that less-skilled surgeons either obtain additional training or refrain from performing those procedures which they are not prepared to do.

The objective of your Subcommittee's proceedings, I believe, must be to insure quality patient care within the framework of the free enterprise system. It would be regrettable to impose unfair or unreasonable restrictions on practitioners of plastic surgery or take any action which might help groups desiring exclusive privileges to establish a medical monopoly. Neither would serve the public interest.

Please let me hear from you if I can be of any further assistance.

Sincerely,

E Gaylon McCollough MD

E. Gaylon McCollough, M.D., FACS

EGMc/rlm

cc: Congressman Norman Sisisky
Congressman Jim Olin
Congressman Elliot Engel
Congressman Michael R. McNulty
Congressman William S. Broomfield
Congressman Larry Combast
Congressman Melton D. Hancock
Frank Papineau
Tom Rhodes, Esq.
Lee VanBremen, Ph.D.
Frank Kamer, M.D.
Ted Cook, M.D.
Bob Simons, M.D.
Regan Thomas, M.D.

FACIAL
PLASTIC
SURGERY

TESTIMONY OF J. REGAN THOMAS, M.D.

Thank you for your invitation to appear before the Subcommittee on the subject of specialization in plastic surgery.

I approach the issue from my position as the head of the Division of Facial Plastic and Reconstructive Surgery in the Department of Otolaryngology-Head and Neck Surgery at the Washington University School of Medicine in St. Louis, Missouri. I have served as the Vice-President for Education of the American Academy of Facial Plastic and Reconstructive Surgery for some years. My positions in education have required me to develop some familiarity with the educational programs in general plastic surgery and facial plastic surgery.

Medical studies universally indicate that physicians believe patients receive better care from specialists than generalists. The history of medical specialization has been a progression from the old-time country doctor who treated everything to modern regional specialists in particular parts of the body. Today, for instance, there are specialists in hand surgery, ear surgery (otologists), brain surgery, eye surgery, and almost every other part of the body. Most physicians agree that a regional specialist who develops a special expertise in a single area of the body offers enhanced patient care.

The phenomenon of regional specialization also appears in plastic surgery. Today there are two basic specialties that overlap in their performance of facial plastic surgery: the specialty of general plastic surgery, and the specialty of facial plastic surgery (which is a subspecialty of otolaryngology/head-and-neck surgery). General plastic surgery addresses the whole body. The general plastic surgeon receives training and operates on the entire body. He performs surgery on the hands, feet, breasts, buttocks, and head and neck.

The facial plastic surgeon focuses his entire training on the head and neck region.

The career paths are similar in some ways and different in others for general plastic surgeons and facial plastic surgeons. The general plastic surgeon receives three years (or, in some cases, more) of general surgery over the entire body. After that, the general plastic surgeon completes his training with two years of general plastic surgery over the entire body. That training provides excellent general surgery experience, some of which applies to the head and neck region.

The facial plastic surgeon generally trains for one year in general surgery and then focuses the remaining four to six years of his residency training in the head and neck region. After that training, the facial plastic surgeon may go on to take a one-year fellowship with the American Academy of Facial Plastic and Reconstructive Surgery.

Both the training I have described for general plastic surgery and the training for facial plastic surgery require at least nine years of post-graduate training after the four years of medical school.

The "super-specialization" in facial plastic surgery, however, is increasingly being recognized as the preferred course. A study in the general plastic surgeons' journal in November 1985 reported that approximately half the graduating residents in general plastic surgery felt their plastic surgical training was of inadequate duration, given the need for regional specialization. That study reported the experience of a major New York medical university. According to the study, a resident in that training program for general plastic surgery received a "wide exposure" to "a variety" of surgical procedures but limited focus on facial plastic surgery. The study noted:

> "[I]t would be presumptuous of him or her [the general plastic surgery resident] to leave the residency with the conviction that he or she has an adequate background to practice the complete spectrum of craniofacial surgery."

The study concluded that "the traditional two-year residency in plastic surgery is inadequate" for facial plastic surgery. (McCarthy, "The Postresidency Fellowship in Plastic Surgery: Its Evolution and Future," Plastic and Reconstructive Surgery, November 1985, p. 792.)

That same study concluded that "the 'occasional' craniofacial surgeon is detrimental to quality patient care" (Id.)

A report in Plastic Surgery News by the American Society of Plastic and Reconstructive Surgeons (the general plastic surgeons' official newspaper) in March 1989 reported that on overwhelming marjority of general plastic surgeons (63%) felt it is impractical to maintain a clinical practice in all of general plastic surgery.

Seventy-one percent of the respondents said they regretted the "narrowing of their scope" of plastic surgery, but that seems a fact of life.

Super-specialization in facial plastic surgery helps the patient. The patient who goes to a facial plastic surgeon for rhinoplasty (plastic surgery of the nose), for instance, can have confidence that the physician has seen almost every possible type of complication that can affect breathing. The "occasional" surgeon in the area (in the words of the general plastic surgeons' article in November 1985), performing that surgery, is not nearly as likely to have comparable experience in complications affecting breathing.

We are saddened to see the former patients brought before the Committee today. We have not brought such patients ourselves, because we do not believe it is in the best interest of the medical treatment for such patients to expose them to this type of proceeding. You may be assured, however, that I and the other facial plastic surgeons here today have seen hundreds of unfortunate surgical results of surgery done by other physicians.. Many of those patients would have received better care had they gone to a facial plastic surgeon specializing in that area of the body.

Specialization in facial plastic surgery helps patients, and Congress and regulatory agencies should foster such specialization.

TESTIMONY OF THE AMERICAN ACADEMY OF DERMATOLOGY

and

THE AMERICAN SOCIETY FOR DERMATOLOGIC SURGERY

before the

SUBCOMMITTEE ON REGULATION, BUSINESS OPPORTUNITIES, AND ENERGY

of the

COMMITTEE ON SMALL BUSINESS

UNITED STATES HOUSE OF REPRESENTATIVES

April 4, 1989

Mr. Chairman, Members of the Committee, Staff, and Interested Parties:

I am G. Thomas Jansen, M.D., a physician who practices dermatology in Little Rock, Arkansas, and a past president of both the American Academy of Dermatology and the American Board of Dermatology. Accompanying me are Edward A. Krull, M.D., chairman of the Department of Dermatology, Henry Ford Hospital, Detroit, Michigan, and a past president of the American Society for Dermatologic Surgery, past vice-president of the American Academy of Dermatology and currently a director of the American Board of Dermatology; as well as Carlton L. Carpenter, Jr., M.D., clinical professor in the Department of Dermatology of the Louisiana State University School of Medicine. Dr. Carpenter is also a past president of the American Society for Dermatologic Surgery.

We are here today on behalf of The American Academy of Dermatology, a national medical/surgical organization representing the vast majority of physicians practicing dermatology in the United States. The Academy has more than 7000 members including approximately 98% of all American dermatologists. In addition, the testimony is also presented on behalf of the membership of the American Society for Dermatologic Surgery, an organization formed in 1970 to promote the optimal care of all patients requiring surgical management of problems which effect their skin, hair, nails and mucous membranes. We appreciate the opportunity to appear before you today and to present our views.

The members of the Academy and of the American Society for Dermatologic Surgery share your concern that cosmetic surgical procedures be performed in appropriate settings by qualified physicians. Our aim is always to provide our patients with all the information they need to make an informed judgement about cosmetic surgery. In our testimony, we shall discuss what a dermatologist is and shall define dermatologic surgery and our training as dermatologic surgeons. We shall conclude by discussing the specific questions which you have raised in your letter of invitation.

What is a Dermatologist?

As defined by the American Board of Dermatology, recognized by the American Board of Medical Specialties, and approved by the Board of Directors of the American Academy of Dermatology, a dermatologist is a physician specializing in the prevention, diagnosis and treatment of benign and malignant disorders of the skin and related tissues of the mouth, external genitalia, hair, and nails. A dermatologist also diagnoses and treats a number of diseases transmitted through sexual activity. Dermatologists use many diagnostic procedures including microscopic and microbiologic examination of the skin and its secretions. Treatment methods used by dermatologists may include externally applied, injected, and internal medications, selected x-ray and ultraviolet light therapy, and a range of surgical procedures using instruments such as scalpels, surgical curettes, electrosurgical units, freezing surgical units, and lasers.

With this background and knowledge, dermatologists are singularly qualified to advise in the care of normal skin by prescribing measures to maintain the skin in a state of health, to make accurate diagnoses and administer treatment for all skin diseases, skin manifestations of internal diseases, and sexually-transmitted diseases. In addition, dermatologists have had extensive training and experience in the management of skin cancers, moles and other tumors of the skin, and in the use of various techniques for the correction of cosmetic defects of the skin. Patients seeking a dermatologist may come directly or be referred by another physician.

Thus, dermatology is an organ-oriented speciality. Dermatologic practitioners utilize multiple medical and surgical techniques and procedures to keep the skin of their patients in its normal state of health and to remedy abnormalities of skin appearance, structure, and function.

Dermatologic Organizations

The American Academy of Dermatology (AAD) was founded 50 years ago and it is the largest dermatologic organization in the country with a membership of over 7000. The stated purposes of the Academy are to: A) maintain the highest possible standards of medical education pertaining to dermatology and related disciplines, B) promote the highest possible standards in clinical practice, education, and research in dermatologic medicine, surgery and related disciplines, C) promote the highest standards of patient care and promote the public interest relating to dermatology, and D) promote the highest standards in allied health professions and services as they relate to dermatology.

The Academy has two major meetings each year, each of which is devoted to the continuing medical and surgical education of its members. Courses on surgical procedures have been part of the program since the 1930's but a major expansion in the surgical offerings occurred during the 50's and 60's. By the 70's in-depth teaching of the basic science of dermatologic surgery and workshops on more complex surgical techniques and cryosurgery were introduced. At the 1988 meeting of the Academy held in Washington, D.C., there were courses and laboratory sessions on basic, intermediate and advanced surgery as well as cryosurgery and laser surgery. Sessions on liposuction, chemical peels, sclerotherapy, hair transplantation, scalp reduction, tissue augmentation, acne surgery and therapy for aging skin were held. There were a total of 46 surgical sessions at this meeting.

The American Society for Dermatologic Surgery (ASDS) is the second largest dermatologic organization in the United States with over 2000 members and it was formed, as discussed elsewhere, in 1970 to assure that appropriate surgical procedures were available to patients with cutaneous problems. At its yearly meeting there are lectures, symposia, courses and laboratories covering a wide spectrum of problems and procedures related to dermatologic surgery.

The Association of Professors of Dermatology (APD) is an organization of chairpersons of dermatology programs with over 120 members. Two years ago, the APD fostered a new academic organization, the Association of Academic Dermatologic Surgeons (AADS). This group represents the surgical directors of dermatology residency programs and the AADS members have conducted surveys to define the amount of dermatologic surgical training in current training programs. All dermatology residency programs in the country at this time have highly qualified directors of surgical training. All programs teach excisional surgery, complex closures, and nail surgery. Eighty-five percent of the programs teach flap surgery and 75% teach tissue augmentation, dermabrasion, punch replacement of facial scars, hair transplantation, laser surgery and sclerotherapy for venous ectasia (spider veins). Over half of the programs teach rhinophyma surgery (surgery to correct external nasal deformities) and chemical peels and a growing percentage formally teach liposuction.

What Is The Training of a Dermatologist?

For the past 35 years, dermatologic training has been supervised by the Residency Review Committee for Dermatology, a body established by the American Board of Dermatology and the Council on Medical Education of the AMA. The Committee acts with authority delegated to it by the Accreditation Council for Graduate Medical Education (ACGME). The ACGME is sponsored by the American Medical Association, the American Hospital Association, the American Board of Medical Specialties, the Council of Medical Specialty Societies and the Association of American Medical Colleges. The approved residency training programs in Dermatology, of which there are currently 105 in the United States, are organized in medical schools or medical centers to provide trainees with the didactic and practical experience to enable them to deliver superior, specialized care to patients with diseases of the skin, hair, nails, and mucous membranes. It is required that the educational and practical experience be varied and broad, progressive and systematic, and of at least four years duration. The first year following graduation from medical school must be a broad-based clinical year of training in medicine, surgery, pediatrics, or an equivalent speciality. At least 75% of each of the three subsequent years must be spent in activities related to the direct care of dermatologic outpatients and inpatients, including consultations, clinical conferences, and inpatient rounds. A vital part of the residency program is the structured study of the basic sciences related to dermatology including allergy, anatomy, bacteriology, biochemistry, embryology, entymology, genetics, histology, immunology, mycology, oncology, parasitology, pathology, pharmacology, photobiology, physiology, serology, virology and the basic principles of therapy by physical agents.

The clinical training must be sufficient to assure a knowledge of and competence in the procedures in allergy and immunology, cryosurgery, dermatologic surgery, dermatopathology, clinical pathology, parasitology, photobiology, physiotherapy, and topical and systemic pharmacology as well as microbiology, including sexually transmitted diseases.

Among these disciplines, the special requirements of the ACGME state that dermatologic surgery must be given special emphasis in the organization and implementation of the training program.

Following completion of this formal training program, candidates apply for examination by the American Board of Dermatology, incorporated in 1932 to elevate and maintain the standards of dermatology. The foundation of the Board stemmed from a growing awareness that specialization in medicine had to be based on adequate training, experience, and competence. The Board itself is sponsored by the American Dermatological Association, the Council on Medical Education of the American Medical Association, and the American Academy of Dermatology. The Board's primary purpose is to protect the public interest by establishing and maintaining high standards of training, education, and qualification of physicians rendering care in dermatology. The objective of all of its activities is to provide assurance that a Diplomate of the American Board of Dermatology possesses the knowledge and skills essential for the provision of competent care for patients with cutaneous problems.

Candidates who have completed the training requirements outlined above are eligible to apply for examination by the Board. Each candidate must present evidence of satisfactory completion of both the broad-based first post-graduate year, and of the three years of training in dermatology in one of the approved programs in the United States or Canada.

The certifying examination of the Board consists of two parts. The first is a comprehensive written examination including but not limited to the following topics: clinical dermatology, preventive dermatology, dermatopathology, cutaneous allergy and immunology, dermatologic surgery, cutaneous oncology, sexually transmitted diseases, internal medicine as it pertains to dermatology, photobiology and cutaneous microbiology as well as anatomy, physiology, biochemistry, radiation physics, radiation therapy, physical therapy, pharmacology, genetics, and electron microscopy as related to dermatology. Considerable emphasis is based on comprehensive knowledge of the literature.

The second part of the certifying examination is of a more practical nature with a special emphasis on clinical and laboratory dermatology, dermatologic surgery, and microscopic dermatopathology. Candidates must pass both part I and part II of the examination in order to be certified.

After meeting the above requirements and passing the examination, the candidate is awarded a certificate acknowledging that he or she has completed the required course of study and clinical training, has met other specific standards and qualifications and has passed the examination conducted by the American Board of Dermatology. The candidate is then referred to as a Diplomate of the American Board of Dermatology, Incorporated.

Beginning with those candidates who pass the certifying examination in 1991 and for all candidates thereafter, the certificate issued by the American Board of Dermatology will be time-limited. Diplomates will then be required to renew their qualifications periodically through a process of examination and evaluation.

What is Dermatologic Surgery?

Dermatologic surgery has been defined by the American Society for Dermatologic Surgery as "that discipline which deals with the diagnosis and treatment of conditions of the skin, hair, nails, mucous membranes, and adjacent tissues using various surgical modalities". The dermatologist functioning as a dermatologic surgeon has demonstrated competence in the diagnosis, medical and surgical treatment of benign diseases and disorders of the skin, benign and malignant tumors, aging skin, and cosmetic problems.

The techniques employed by dermatologic surgeons include those that accomplish tissue ablation and lesion removal, primary closure, adjacent tissue transfers, and tissue augmentation. Specifically, these include excision and closure, flap surgery, cryosurgery, chemical surgery, dermabrasion, hair replacement surgery, soft tissue augmentation, tissue expansion, incisional surgery, Moh's micrographic surgery, grafting, laser surgery, curettage and dessication, liposuction, sclerotherapy, micropigmentation, destructive techniques, and nail surgery.

Most commonly, these procedures, with the utmost safety to our patients, can be most effectively and efficiently performed in an ambulatory setting, which may be either an office surgical suite or an ambulatory surgical center. Under special circumstances, dermatologic surgical procedures may be done in a hospital operating room.

The American Society for Dermatologic Surgery (ASDS) has developed a core curriculum for dermatologic surgery in residency programs, and has also developed surgical case logs to be used throughout the residency programs, during the process of Board Certification and subsequently during Continuing Medical Education programs. The data developed from these logs indicate, as detailed previously, that surgical training in dermatologic residencies is extensive.

During the past year, as described above, a survey was undertaken of the extent of dermatologic surgical experience in dermatologic training programs. That survey revealed that in all programs excisional surgery with complex closures and nail surgery are being taught. Tissue augmentation, dermabrasion, hair transplantation, laser surgery, rhinophyma surgery and cryosurgery are taught in the majority of programs.

To summarize, dermatologic surgeons are dermatologists who use the surgical techniques defined above in addition to medical procedures in order to treat their patients. Dermatologists are not restricted to the use of specific diagnostic and therapeutic techniques; they focus upon an entire organ and its problems.

Board certified dermatologists are not plastic surgeons, they are not cosmetic surgeons--they are specialists in the medical and surgical therapy of cutaneous surfaces. They share a number of areas of expertise with board certified plastic surgeons, board certified otolaryngologists and, in some cases, board certified general surgeons. In addition and in contrast to these other specialists, the dermatologist/dermatologic surgeon is trained and prepared to use non-surgical procedures to solve the problems presented by patients with cutaneous problems. These procedures include the use of systemic and topical treatments including those aimed at sun- and age-damaged skin as well as hair growth.

Specific Techniques Utilized in Dermatologic Surgery

There are a large number of procedures utilized in dermatologic surgery, the majority of which have been developed primarily by dermatologists.

Basic incisional surgery as well as excisional surgery and closures have been performed by physicians and other medical practitioners for close to 3000 years. The use of skin flaps to close wounds was introduced 2700 years ago although each of these techniques have been vastly improved recently due to the contributions of many specialists including dermatologists. Tissue expansion techniques have been developed predominantly by plastic surgeons while the field of small flap surgery has been expanded greatly by dermatologists over the past 20 years. Skin grafting began in the early 19th century but again much recent progress may be attributed to a variety of specialists including dermatologists who have taken the lead in the area of epidermal grafts.

Liposuction was developed by Pierre Fournier, a Parisian physician, in the mid-70's and it was first introduced in the United States at a meeting of the American Society for Dermatologic Surgery in 1980. Before 1980, no one in this country was trained to perform liposuction and, thus, no physician who finished training before 1980 was introduced to liposuction during residency. Since 1980, through post-graduate education courses, liposuction has become part of the expertise of a number of specialties including dermatology, plastic surgery, and otolaryngology.

Cryosurgery, which includes the use of carbon dioxide slush and liquid nitrogen, was developed by dermatologists. The most eminent authority in the country is Setrag Zacarian, M.D. of Boston University. Chemical surgery, including chemical peels, was introduced in the mid-50's by two dermatologists, George Miller McKee and Florentine Karp of New York University. Dermabrasion was introduced soon after the turn of the twentieth century by Kronmayer, a German dermatologist, and it was developed in the United States by a group of dermatologists including Eller, Kurtin, Burks and Ayers. Hair replacement surgery can be attributed to Norman Orentreich, a dermatologist who currently is a professor at New York University. Soft tissue augmentation, which includes the use of silicon as well as collagen has been perfected by a variety of medical specialists including such dermatologic leaders as Samuel Stegman and Theodore Tromovitch of San Francisco and Norman Orentreich of New York.

Microscopically controlled surgery was introduced by Frederick Mohs, a general surgeon from Madison, Wisconsin, who was studying mammary neoplasms. The critical modification of microscopically controlled surgery was made in 1974 by Drs. Tromovitch and Stegman when they introduced the fresh-tissue technique. This has permitted Mohs Surgical Techniques to become widely available for many patients with skin cancer.

The pioneer in laser surgery of the skin in the United States was Leon Goldman, chairman of the Department of Dermatology at the University of Cincinnati. Since Dr. Goldman introduced the technique in the 1960's, physicians in many specialties have utilized laser procedures for the benefit of their patients and training in dermatology residency programs in laser surgery has become as extensive as in any other medical specialty.

Curettage and dessication and other destructive techniques of skin tumors were introduced and perfected by dermatologists and the use of saline for sclerotherapy to ablate dilated veins was developed and promoted by dermatologists.

The field of nail surgery in this country has been pioneered by dermatologic surgeons including Edward Krull of the Henry Ford Hospital in Detroit and Richard Scher, currently a clinical professor of dermatology at the Columbia University College of Physicians and Surgeons.

Specific Interests of the Subcommittee

You have requested a response to a number of issues related to what is described as the current explosion of cosmetic surgery procedures being performed nationwide.

First, you asked about the attempt of consumers to find qualified and adequately trained surgeons to perform elective cosmetic surgery. It is our belief that by seeking consultation from physicians who are diplomates of the American Board of Dermatology, patients will be able to find qualified and adequately trained physicians to perform the dermatologic surgery which they require. In addition, if they contact a specialist certified by the American Board of Plastic Surgery, the American Board of Otolaryngology, or in many cases the American Board of Surgery, the same circumstances would hold true. To assist patients, the ASDS maintains an "800" telephone number for referrals to dermatologic surgeons. The AAD provides patients with the names of qualified dermatologists within their appropriate geographic area.

In the case of the American Board of Dermatology, it again should be emphasized that in 1991 the Board will begin to issue time-limited certificates, thus helping to ensure the continued competence in dermatologic surgery of actively certified diplomates.

With regard to the factors which are prompting the growing numbers of consumers who are opting for elective cosmetic procedures, as dermatologists we deal daily with patients' concerns about problems of their skin which affect their appearance. Such changes in the skin often relate to the quality of life and to the self-image of our patients. Procedures such as hair transplantation and dermabrasion, among others, have been developed and are effective in treating such cosmetic problems. We do not believe it is surprising that patients seek such effective care.

You are concerned about cosmetic procedures being performed by unqualified and/or less-than-adequately trained surgeons. We do not know how prevalent a situation this is, and would appreciate hearing from the committee its views about the numbers involved. We are certain that diplomates of the American Board of Dermatology are qualified by training and experience to perform the procedures carried out on their patients.

Your next question basically deals with informed consent. The members of the American Academy of Dermatology and the American Society for Dermatologic Surgery are urged to follow the accepted guidelines for informed consent. These require that patients be apprised of the risks and benefits of all procedures before they are undertaken. Our principles of professional conduct require that our members provide their patients with an explanation of the cause, treatment and progress of their disease.

The issue of ambulatory surgical facilities is one on which the Task Force on Standards of Care of the American Academy of Dermatology is currently working. By the end of 1989, they plan to present their guidelines for ambulatory surgery. The majority of surgery performed by dermatologists is, in fact, office-based. This is a safe environment which leads to efficient care at much lower costs for procedures than equivalent surgery which is performed in ambulatory surgery centers or in the hospital. As an example of the issues being analyzed by the members of this Task Force, they are currently developing criteria by which we define the types of liposuction procedures which can be performed safely in offices without life support monitoring equipment. For any procedures outside of this group, the task force will define the types of life support monitoring equipment required.

You raise the question of advertising. It must be pointed out that the Federal Trade Commission has, within recent years, permitted medical advertising which was not previously acceptable and has forbidden medical organizations such as ours from policing and discipling advertisers who overstep what we believe to be appropriate bounds. The American Academy of Dermatology and the American Society for Dermatologic Surgery, as part of their Code of Ethics, have adopted strong guidelines stating that physicians should not engage in advertising that is false, fraudulent, deceptive, or misleading. If the members of your subcommittee feel that medical advertising should be limited to protect consumers, that is an issue which has to be dealt with in conjunction with the Administration and the Federal Trade Commission. We would be pleased to assist in the development of an approriate approach through legislation or otherwise.

You ask whether current government oversight and/or peer review by the medical community is adequate to ensure public safety. Currently, there is significant peer review in hospitals and in institutionalized ambulatory surgery centers. However, this peer review is limited in its effectiveness because of the perceived risk of liability by participants in the peer review process. We believe that Congress must take steps to protect the participants in this peer-review process if it is to be effective. Subsequently, we must develop an effective peer-review process for office-based procedures. Both the American Academy of Dermatology and the American Society for Dermatologic Surgery have started to deal with this issue. The American Society for Dermatologic Surgery has defined, as one of its major strategic directions, the need to establish a process of office-based peer review. The Society has stated that all physicians who seek membership in the ASDS must submit to peer review as a condition for membership. Additionally, it proposes that the process would be activated by a complaint from either a physician or a patient and the peer review would be conducted by a committee of the American Society for Dermatologic Surgery. If the review determines that the complaint is valid, the Society would perform educational counseling.

This same area is being dealt with by the Task Force on Standards of Care of the American Academy of Dermatology. The Task Force members are developing guidelines in a variety of areas including acne, atopic dermatitis, basal cell carcinoma, benign pigmented lesions, liposuction, psoriasis and office-base surgery.

You also ask whether the existing Board Certification process is an appropriate and adequate means of protecting the public from unqualified doctors. It is our belief that certification by one of the 23 member Boards of the American Board of Medical Specialties goes far enough to make certain that physicians entering upon a specialty practice are qualified. The recent addition of time-limited certification, a move which the American Board of Dermatology has endorsed, means that this certification process will serve even more to protect the public from unqualified doctors if the public seeks care from diplomates of the 23 member Boards of the American Board of Medical Specialties.

Finally, you request our views on how the government and the medical community can work together to assure the safety of cosmetic surgical procedures being performed and to take any actions necessary to ensure the public health. We completely share your belief that the most important issue is that medical care be delivered by appropriately trained physicians in an appropriate manner. It is only through consultation among members of the medical profession and members of the government that such an aim will be met. We look forward to working with you on these and other related issues in the future.

EXECUTIVE SUMMARY

TESTIMONY OF THE AMERICAN ACADEMY OF DERMATOLOGY AND THE AMERICAN SOCIETY FOR DERMATOLOGIC SURGERY

This testimony will be presented on April 4, 1989, before the Subcommittee On Regulation, Business Opportunities and Energy of the Committee on Small Business, House of Representatives, by G. Thomas Jansen, M.D., Edward A. Krull, M.D., and Carlton Carpenter, Jr., M.D., on behalf of the American Academy of Dermatology (AAD) and the American Society for Dermatologic Surgery, (ASDS).

The training and qualifications of Board-certified dermatologists, who specialize in the treatment of the skin, hair, nails, mouth and external genitalia will be reviewed. The training of dermatologists includes graduation from an accredited medical school and at least four years of residency training. The first year must be in a broad-based clinical program and the next three spent in one of the 105 residency programs in dermatology located in hospitals and medical centers in the U.S. Following completion of this course of study, candidates are eligible for examination by the American Board of Dermatology (ABD).

An essential component of dermatological residency programs is work in dermatologic surgical procedures, including incisional and excisional surgery, cryosurgery, dermabrasion, hair transplantation, grafts and flaps and laser surgery. These procedures are integral parts of all dermatology residency programs. In fact, dermatologists pioneered or participated in the development of the majority of these procedures.

These training programs plus continuing medical education in surgery--at the 1988 AAD Annual Meeting 46 courses in surgery were offered to the dermatologists attending the meeting--prepares members of the AAD and the ASDS to deliver dermatologic surgical care to their patients in an efficient, effective, safe manner. The majority of this care is delivered in office surgical suites or in ambulatory surgical facilities. In addition, dermatologists are trained to deliver non-surgical care for a variety of cosmetic and non-cosmetic cutaneous problems. Since then, through continuing medical education, liposuction has become part of the expertise of a number of specialties including dermatology, plastic surgery and otolaryngology. To meet the continuing needs of the public and of the specialty, the AAD and the ASDS are participating in the definition of Standards of Care in areas which include acne, basal cell carcinoma, pigmented lesions, liposuction and office-based surgery.

RESPONSE TO SUBCOMMITTEE QUESTIONS

It is the belief of the AAD and ASDS that by seeking consultation from diplomates of the American Board of Dermatology, patients will find qualified and adequately trained physicians to perform dermatological surgery including dermatologic cosmetic procedures.

Concerning the factors which prompt the growing numbers of consumers to seek elective cosmetic surgery, as dermatologists we know that appearance is important to all. Effective procedures are available and patients seek them.

The AAD and ASDS members follow accepted guidelines for informed consent. These guidelines require that patients be provided with an explanation of the cause, treatment, and progress of their disease. The risks and benefits must also be fully explained.

The issue of ambulatory surgical facilities is being evaluated by the AAD Task Force on Standards of Care. Guidelines will be presented in 1989. Guidelines are also being prepared covering acne, dermatitis, skin cancer, psoriasis, liposuction and office-based surgery.

The question of advertising has been raised by the Subcommittee. It must be pointed out that the Federal Trade Commission has forbidden medical organizations such as ours from policing and disciplining members who engage in inappropriate advertising. We must look to Congress, the Administration, and regulatory agencies for remedies to this situation.

The AAD also believes that measures must be taken to protect participants in the peer review process. We must also develop an effective peer review process for office-based procedures. The ASDS has stated that all physicians who seek membership in the Society must submit to peer review as a condition for membership. Of import to the issue of continuing competence of dermatologic surgeons, the American Board of Dermatology, as of 1991, will issue time-limited certificates. This means that diplomates will be periodically reevaluated for certificates instead of the current indefinite validity of a specialty certificate.

CONCLUSION

The AAD and ASDS offer their assistance in working with the Subcommittee and others to assure the public receives highest quality dermatologic surgical care, including cosmetic dermatologic surgical care, from trained physicians.

AMERICAN ACADEMY OF DERMATOLOGY 1938

news release

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DERMATOLOGISTS SUPPORT CONSUMER CONCERNS ABOUT COSMETIC SURGERY

WASHINGTON, D.C. -- April 4, 1989 -- G. Thomas Jansen, M.D., representing the nation's two largest dermatological professional societies, today told a Congressional subcommittee that dermatologists share Congressional concern that people seeking cosmetic surgery receive safe and competent care.

"The members of the American Academy of Dermatology (AAD) and of the American Society for Dermatologic Surgery (ASDS) share your concern," he said in prepared testimony, "that cosmetic surgical procedures be performed in appropriate settings by qualified physicians." In addition, he said, "The dermatological societies encourage their members to provide patients with all the information on benefits and side effects needed to make informed judgments about cosmetic surgery."

Dr. Jansen, a dermatologist and dermatologic surgeon for over 33 years in Little Rock, AR, is a past president of AAD and past president of the American Board of Dermatology. He was joined by colleagues Edward A. Krull, M.D., and Carlton L. Carpenter, M.D., before the U.S. Congressional

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Subcommittee on Regulation, Business Opportunities, and Energy, chaired by Representative Ron Wyden of Oregon.

Dr. Krull, chairman of the Department of Dermatology, Henry Ford Hospital, Detroit, Michigan, is a past president of ASDS, past vice-president and currently a director of the American Board of Dermatology. Dr. Carpenter, a clinical professor in the Department of Dermatology of the Louisiana State University School of Medicine, is a past president of the ASDS.

The AAD and the ASDS were asked to provide information to the subcommittee.

Referring to the increase in elective cosmetic surgery, he said, "We do not believe it is surprising that patients seek such effective care."

"As dermatologists, we deal daily with patients' concerns about problems of their skin which affect their appearance. Such changes in the skin often relate to the quality of life and to the self-image of our patients."

In reviewing various dermatologic surgical procedures, Dr. Jansen responded to comments about liposuction, a technique developed in France in the 1970s. The very popular procedure, which involves sculpting the body by removing pockets of excess fat from certain areas, is now provided by several surgical specialties.

Dr. Jansen suggested that consumers can find qualified and adequately-trained surgeons to perform elective cosmetic surgery by consulting with physicians certified by the American Board of Dermatology, the American Board of Plastic Surgery, the American Board of Otolaryngology, or, in many cases, the American Board of Surgery.

-more-

Dr. Jansen noted the special expertise of dermatologic surgeons.

"Dermatologists have had extensive training and experience in the use of various techniques for the correction of cosmetic defects of the skin."

Basic laboratory and clinical research is being carried out by dermatologists in liposuction surgery and a related procedure, microlipoinjection. The research has already provided added safety and better results at less expense to patients undergoing these cosmetic dermatologic surgical procedures.

Dr. Jansen underscored the importance of approved residency training programs, continuing medical education, and certification, including periodic recertification, of physicians in their specialties.

He described the requirements of the 105 approved residency training programs in dermatology in medical schools and centers throughout the U.S.A. supervised by the Residency Review Committee for Dermatology. The committee, established by the American Board of Dermatology and the Council on Medical Education of the American Medical Association, acts with authority delegated to it by the Accreditation Council for Graduate Medical Education (ACGME).

ACGME requires that surgery be given special emphasis in residency programs.

Addressing the subcommittee's concern about how consumers can find qualified and adequately trained surgeons to perform cosmetic surgery, Dr. Jansen said, "It is our belief that certification by one of the 23 member boards of the American Board of Medical Specialties helps ensure that physicians entering upon a specialty practice are qualified.

-more-

"The recent addition of time-limited certification, a move which the American Board of Dermatology has endorsed means that this certification process will serve even more to protect the public.," he concluded.

Peer review is also vital, Dr. Jansen pointed out.

"Currently, there is significant peer review in hospitals and in institutionalized ambulatory surgery centers. However, this peer review is limited in its effectiveness because of the perceived risk of liability by participants in this peer-review process."

"We (AAD and ASDS) believe that Congress must take steps to protect the participants in this peer review process if it is to be effective. "Subsequently, we must develop an effective peer review process for office-based procedures," Dr. Jansen concluded.

ASDS has defined, as one of its major strategic directions, the need to establish a process of office-based peer review. The Society has stated that all physicians who seek membership in the ASDS must submit to peer review as a condition to membership.

It proposes that the process be activated by a complaint from either a physician or a patient and that the peer review be conducted by a committee of the Society.

In addition, the AAD Task Force on Standards of Care is developing guidelines in a variety of areas of treatment, ~~including~~ office-based surgery. To date, guidelines for liposuction have been approved by the Executive Committee of the AAD Board of Directors.

In concluding his remarks, Dr. Jansen noted that both dermatologic organizations look forward to continued cooperation between the government and medical communities to assure the safety of cosmetic surgical procedures being performed and to take any actions necessary to ensure the public health.

AMERICAN ACADEMY of DERMATOLOGY, Inc.

CHAIRMAN,
COUNCIL ON GOVERNMENTAL LIAISON
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NYU Medical Center
Department of Dermatology
560 First Avenue
New York, NY 10016
Area Code (212) 340-5245

April 24, 1989

The Honorable Ron Wyden, Chairman
Subcommittee on Regulation and Business Opportunities
House Small Business Committee
B363 Rayburn House Office Building
Washington, DC 20515

Dear Congressman Wyden:

Following the hearing held by your Subcommittee on Tuesday, April 4, 1989, the American Academy of Dermatology and the American Society for Dermatologic Surgery were asked about our position on dermatologists performing breast implants and "tummy tucks." In addition, we were asked what "cosmetic" procedures are not within the jurisdiction of our members.

Although there may be a small number of dermatologists who have obtained the requisite training following residency to become proficient in performing breast implants and "tummy tucks," these procedures are not taught during dermatologic residency or during dermatologic surgical fellowships. Therefore, the vast majority of dermatologists do not perform these procedures.

The term "cosmetic" procedures is too broad for us to list accurately the procedures which are not within the "jurisdiction" of our members. The important issue is what cosmetic procedures we believe dermatologists in 1989 are trained to undertake. These include, but may not be limited to, the following:

- Chemical peels;
- Cryosurgery and electro-surgery;
- Dermabrasion and punch graft placement for depressed facial scars;
- Epidermal grafts;
- Excision with cosmetic repair including flaps and grafts on all areas of the body;
- Hair transplantation and scalp reduction;

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AMERICAN ACADEMY of DERMATOLOGY, Inc.
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April 24, 1989
Page 2 of 2

- Laser surgery for vascular lesions, skin tumors, and other cutaneous problems;
- Liposculpting (Liposuction) in all areas of the body;
- Mohs micrographic surgery with appropriate cosmetic repair;
- Nail surgery;
- Punch grafts for vitiligo;
- Rhinophyma surgery;
- Sclerotherapy of veins;
- Tissue augmentation with collagen, autologous fat and other materials;
- Tissue expansion.

I trust this information will be helpful to you as you write the subcommittee report. From our perspective, the important issue is that dermatologists initially developed or significantly contributed to each of these procedures. They are a part of appropriate dermatologic therapy.

In addition, we would like to emphasize that most of the cosmetic procedures performed by our members are not performed in the hospital. These are techniques quite appropriate for physician offices and any credentialing for them must relate to the office environment and not to hospital privileges.

Sincerely,

Irwin M. Freedberg

Irwin M. Freedberg, M.D.

IRF/vjs

cc: G. Thomas Jansen, M.D.
Edward A. Krull, M.D.
Carlton L. Carpenter, M.D.

bc: Roberta L. Sorensen
John T. Grupenhoff, Ph.D.
Deborah Steelman, J.D.
Peyton E. Weary, M.D.
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AMERICAN ACADEMY OF OPHTHALMOLOGY

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May 22, 1989

The Honorable Ron Wyden
2452 Rayburn House Office Building
Washington, D.C. 20515

ATTN: Phyllis Albritton/Donald Gross

Re: Comments for April 4, 1989 Hearing Record on "Unqualified Doctors and the Risks of Cosmetic Surgery"

Dear Congressman Wyden:

The American Academy of Ophthalmology appreciates the opportunity to comment on the issue of unqualified doctors and cosmetic surgery. We believe that Board Certified Ophthalmologists, who must be members of the American Academy of Ophthalmology, are qualified by their training to perform some periocular reconstructive surgical procedures. Board Certified Ophthalmologists, as Fellows of the Academy, have successfully completed a rigorous residency program and have received training in plastics as part of their residency requirements.

In addition to the general ophthalmologist who may perform certain oculoplastic procedures as part of their practice, are those ophthalmologists who specialize further in the field of plastics through a fellowship following their residency training. These ophthalmologists have satisfied the criteria of the American Society of Ophthalmic Plastic and Reconstructive Surgery and represent the leadership in this specialized area, developing new and more refined procedures and educating our membership. Most are involved within university medical centers around the country and it is this group which trains our residents. Surgery of the eyelids for pathologic states, most often performed by members of this society, includes blepharoptosis, congenital or traumatic deformities, and reconstruction procedures for tumor management.

As ophthalmologists primarily concerned with eye care and the general and visual health of our patients, we decry misleading advertising and claims made by any medical practitioner. Not only are ophthalmologists often the best qualified to perform periocular cosmetic and reconstructive surgery, but often are required to manage the complications of facial aesthetic surgery due to their significance impact on the eyes.

The Honorable Ron Wyden
May 22, 1989
Page Two

We appreciate the opportunity to comment on this issue of concern.

Sincerely,

Michael A. Lemp, M.D.
Associate Secretary for
Research, Regulatory Agencies
and Federal Systems

AMERICAN BOARD OF MEDICAL SPECIALTIES
One Rotary Center, Suite 805 Evanston, Illinois 60201-4889 312/491-9091

Members
American Board of Allergy & Immunology
American Board of Anesthesiology
American Board of Colon & Rectal Surgery
American Board of Dermatology
American Board of Emergency Medicine
American Board of Family Practice
American Board of Internal Medicine
American Board of Neurological Surgery
American Board of Nuclear Medicine
American Board of Obstetrics & Gynecology
American Board of Ophthalmology
American Board of Orthopaedic Surgery
American Board of Otolaryngology
American Board of Pathology
American Board of Pediatrics
American Board of Physical Medicine
  and Rehabilitation
American Board of Plastic Surgery
American Board of Preventive Medicine
American Board of Psychiatry & Neurology
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American Board of Thoracic Surgery
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REP. RON WYDEN

January 23, 1989

The Honorable Ron Wyden
Chairman
Subcommittee on Regulation & Business Opportunities
House Small Business Committee
B363 Rayburn House Office Building
Washington, DC 20515

Dear Congressman Wyden:

I understand that your Subcommittee has been interested in the problem which the public has in identifying the meaning of a statement or advertisement by a physician to the effect that he or she is "board certified".

To most citizens, being board certified means that a physician has achieved a high level of specialist competence by virtue of training and successful completion of a rigorous examination. However, that assurance does not always obtain. The unfortunate fact is that any individual or group can organize a "board", can issue certificates under any requirements it establishes and those requirements may vary from no training or substituting experience for an examination to the very rigorous requirements of the 23 Boards which are members of the ABMS (listed on this letterhead) and which are so recognized by the American Medical Association and the American Board of Medical Specialties. It was for this very reason that the ABMS was established in 1933. It has a process for recognizing and approving new boards through the Liaison Committee on Specialty Boards (LCSB), a creature of the American Medical Association and the American Board of Medical Specialties. That process is described in the enclosed Essentials for the Approval of Examining Boards in Medical Specialties. Only the 23 Boards listed on this letterhead have met those requirements to date.

On the other hand we are aware of at least 102 self-designated boards and enclose a list of those which we understand do exist. We have no information about their standards or their requirements. We only know that some of them advertise their existence to physicians inviting them to obtain the certification of that board. We also know that many physicians who obtain such certification advertise it to the public.

The citizen who is confused by these allegations of being board certified is at a disadvantage. The citizen has no way of understanding the complicated process of approval of boards either by the ABMS/AMA or by the American Osteopathic Association in the case of Osteopathic Boards. The term "board certified" is meaningful only if the public can be assured that the board has met high standards and has a process to offer assurance of accredited training and successful completion of a rigorous evaluation. That is the very reason for the ABMS and the LCSB. We have tried to increase public awareness of this situation but you will understand what a complex issue this has become and what a challenge it is to educate all of the citizens of this country about it.

I would hope that your Subcommittee would consider some type of legislation which states that one who represents himself to be a certified medical specialist is one who is certified by a Member Board of the American Board of Medical Specialties or the American Osteopathic Association. This could be approached in a variety of ways either through legislation on false and deceptive advertising or on legislation concerning payment for medical services from federal funds. I understand that at least two states have investigated this issue but it is so complicated that legislation at the federal level might be advantageous if it is within the purview of federal authority.

The American Board of Medical Specialties would be delighted to offer further information or to present testimony on this issue. Please do not hesitate to contact us.

Cordially,

Donald G. Langsley, M.D.
Executive Vice President

DGL/bh/10

Enclosures (2)

cc: ABMS Executive Committee

APPROVAL OF EXAMINING BOARDS IN MEDICAL SPECIALTIES

Since 1934, medical specialty boards have been officially approved by action of the erican Board of Medical Specialties (ABMS) and the American Medical Associa- n Council on Medical Education (AMA/CME). This determination begins with view by the Liaison Committee for Specialty Boards (LCSB), an organization onsored by the AMA/CME and the ABMS.

The LCSB consists of four voting representatives from the ABMS Executive Commit- e and four voting representatives from the AMA/CME. The Chairman of the AMA/ 1E serves as Chairman of the LCSB. The Executive Vice President of the ABMS rves as Secretary of the LCSB (without vote). The Secretary of the AMA/CME also rves on the LCSB (without vote). The LCSB meets on the call of the Chairman at no ed intervals, but generally meets annually.

The functions of the LCSB are:
to receive applications for approval as a medical specialty certifying board.
to evaluate applications according to the current version of the "Essentials for Approval of Examining Boards in Medical Specialties."
to hold hearings on such applications if appropriate to do so.
to have the Secretary forward approved applications to the sponsors of the LCSB (the ABMS and the AMA) along with the recommendations of the LCSB. Both the AMA/CME and the ABMS must act affirmatively by a ⅔ majority if a new board is to be approved. LCSB is not required to ratify the actions of its sponsors.
to notify the applicant of the action of the sponsors of LCSB. If the application is disapproved, the applicant may reapply after 12 months.

Action on applications for approval of examining boards in medical specialties is sed on the *Essentials for Approval of Examining Boards in Medical Specialties*, a llaboration effort of the ABMS and the AMA/CME begun in 1934. The original sentials *for Approval of Examining Boards in Medical Specialties* was based on commendations of the ABMS Committee on Standards and Examinations and was proved by the AMA House of Delegates in June, 1934. The *Essentials* have dergone several revisions, both major and minor, since 1934. The present, tenth vision of the *Essentials* is a joint document approved by both organizations. It cludes the policies of both the ABMS and the AMA pertaining to specialty boards ile retaining each organization's privilege of independent consideration and action. e *Essentials* describe the standards and procedures by which applications for proval of new examining boards are evaluated.

The approved specialty boards and the current list of categories of certification in ch of these specialties are listed on the inside front cover of this edition of the ABMS nual *Report and Reference Handbook.*

TENTH REVISION OF
ESSENTIALS FOR APPROVAL OF EXAMINING BOARDS
IN MEDICAL SPECIALTIES

Approved by ABMS September, 1986 and by AMA December, 1986

Section I. Function of the Liaison Committee for Specialty Boards (LCSB).

The American Board of Medical Specialties (ABMS), by authority of its member boards and other member organizations, and the American Medical Association Council on Medical Education (AMA/CME), by authority delegated by the AMA House of Delegates, have established the LCSB consisting of four representatives selected from each body. The Chairman of the AMA/CME shall be the Chairman of the LCSB. The Executive Vice President of the ABMS shall be the Secretary of the LCSB but shall not vote. The Secretary of the AMA/CME shall attend meetings of the LCSB but shall not vote.

The purpose of the Liaison Committee is:

A. To receive applications for approval of medical specialty boards and make recommendations to its parent bodies.

B. To provide a mechanism for contact with petitioning groups through the Secretary of the LCSB on matters related to approval of new specialty boards and for transmission of decisions of the ABMS and AMA/CME to applicants.

C. To determine as expeditiously as possible if the applicant board has complied with the Essentials for approval.

To assist in attaining these objectives, the LCSB is authorized to appoint consultants known to the ABMS and the AMA/CME to be qualified and knowledgeable in the special field which the new specialty board intends to represent.

Section II. Definition of a Specialty Board.

A specialty board is a separately incorporated, financially independent body which determines its requirements and policies for certification, selects the members of its governing body in accordance with the procedures stipulated in its bylaws, accepts its candidates for certification from persons who fulfill its stated requirements, administers examinations, and issues certificates to those who submit to and pass its evaluations.

Section III. Objectives and Functions of Specialty Boards.

A fundamental objective of all approved boards is to act in the public interest by contributing to the improvement of medical care by establishing the qualifications for candidates and by evaluating individuals who apply for certification.

The primary function of all approved specialty boards is to evaluate the qualifications of candidates who apply and to certify as Diplomates those who are found to be qualified.

accomplish this function, specialty boards shall:

etermine whether or not candidates have received adequate preparation in ccord with educational standards established by the specialty board.

onduct comprehensive evaluations of the knowledge and experience of such andidates, and

sue certificates to those physicians found qualified under the stated requirements f the board.

related function of approved specialty boards is to assist in maintaining and ing the standards of graduate medical education and facilities for specialty ng in collaboration with other concerned organizations and agencies.

ction *IV.* **Criteria for Approval of New Examining Boards.**

he establishment of a new specialty board signifies the differentiation of a new pecialty which must be based on major new concepts in medical science.

new medical specialty board must represent a distinct and well defined field of edical practice. It may entail special concern with the problems of patients ccording to age, sex, or organ systems or with the interaction between patients nd their environment.

new certifying board must be based on substantial advancement in medical ience. The needed training must be sufficiently complex or extended that it is not asible to include it in established training programs.

board must require evidence that its diplomates have acquired capability in a ated area of medicine and will demonstrate special knowledge in that field.

plan must be presented whereby preparatory programs in graduate medical ducation will be developed for accreditation by the Accreditation Council for raduate Medical Education (ACGME). New boards may be permitted under onditions stated by the petitioning board and approved by the LCSB, to approve aining or experience or a combination of both as equivalent to that acquired in ccredited training programs until accreditation by the ACGME is in place.

he applicant must present satisfactory evidence that the proposed board has oad professional support in the specialty, and that approval will promote and hance recognition of a single standard of preparation for practice in each ecialty.

order to promote public and professional understanding and recognition of a ngle standard in each specialty and to promote efficiency of the evaluation ocess, only one certifying board will be recognized in each specialty.

G. While it is recognized that considerable variation among certifying boards may be permitted, the operational plan must include satisfactory details in the following areas:

(1) Names, professional affiliations and professional accomplishments of the sponsors.

(2) Structure—the composition of the board should provide for representation of appropriate organizations and for effective operation of the board.

(3) Content of the field—data from a detailed analysis of the professional area, including present and future public needs and professional interests should be presented. Such analysis should be used for development and continued evaluation of standards for certification.

(4) While requirements may not be fully developed at the date of application, a plan for development and validation of the requirements should be presented.

(5) A detailed plan for evaluating individual candidates should be presented.

(6) The financial support for a valid, objective program of candidate evaluation, as well as other necessary activities in graduate education must be included in the plan. The data presented should include projected numbers of potential diplomates and projected certification fees.

Section V. **Procedure for Approval of New Specialty Boards.**

A. The application should be directed to the Secretary of the LCSB who also serves as Executive Vice President of the ABMS.

B. The LCSB may conduct a hearing before making a recommendation on any application.

C. The application should adhere to the following outline:

(1) The name of the proposed specialty board asking for approval.

(2) The proposed objectives and function of the petitioning board.

(3) The names of the sponsoring organizations.

(4) A detailed statement describing how compliance with each of the criteria in Section IV is achieved.

(5) A description of the proposed organization, the names and professional qualifications of the proposed officials, the names and addresses of the founding members, their qualifications, and the organization which each member represents.

(6) A copy of the proposed or existing Constitution and Bylaws.

(7) A copy of the proposed or existing Articles of Incorporation.

(9) The number and names of institutions providing residency or other acceptable training programs in the specialty, the total number of residencies available, and the number of residency training programs that can be developed.

(10) The approximate number of physicians engaged in the practice of the specialty.

(11) A copy of the proposed application form for candidates for certification.

(12) Provisions, if any, for certifying physicians practicing in the specialty without examination or accredited training. The statement should include the qualifications and the number of physicians to be certified in that manner.

D. The responsibility of the LCSB is not limited to initial evaluation of the certifying boards in medical specialties. Proposed changes in policy which differ substantially from those policies and procedures which prevailed at the time of approval should be reported to the Secretary of the LCSB for transmittal to the LCSB for action as required.

The LCSB shall submit a report and recommendations to the ABMS and the AMA/CME for consideration by their members within one year after receipt of the application.

The ABMS and the AMA/CME shall independently act on the application after receiving a recommendation for approval from the LCSB. An affirmative vote of two-thirds of the members of each of the ABMS and the AMA/CME, present and voting provided a quorum is present, is required to approve the new board. Each parent of the LCSB shall report its action to the Secretary of the LCSB. If one of the parents disapproves, it must transmit the reasons for disapproval to the LCSB.

If possible, within twelve months of receipt of the application as defined in Section V.C., the LCSB shall inform the petitioning group of their decision. If the decision is negative the petitioner may request reconsideration by the LCSB which could include an opportunity for the petitioner to be heard in person. Following reconsideration by the LCSB, the provisions of Section V.F. will apply. The LCSB will then transmit the final action of the parents of the LCSB, after reconsideration, to the petitioner.

The petitioner may file a formal appeal in the event of a negative decision in the reconsideration process. This will be initiated by a request for an appeal to the Secretary of the LCSB who will transmit that information to the ABMS and the AMA/CME. The appeal will be heard by a five-person panel consisting of two members of the ABMS Executive Committee who are not members of the LCSB (appointed by the ABMS Executive Committee) and two members of the AMA/CME who are not members of the LCSB (appointed by the AMA/CME). These four individuals will chose a "public member" who may not be a member of the ABMS or the AMA/CME. The appeals panel will hear the appeal of the petitioner and would then transmit its recommendations to the LCSB. After considering the recommendations of the appeals panel, the LCSB will take final action on the appeal and will notify both the petitioners and the parents of the LCSB.

Following approval by the LCSB, ABMS, and AMA/CME, the board shall not issue new certificates to individuals who received certification prior to approval without requiring that each meet the same requirements as candidates applying for board

Section VI. Meetings of the LCSB.

The LCSB shall meet at least annually at the call of the Chairman. On petition of five members of the LCSB, the Chairman shall call a special meeting. The Chairman may also call a special meeting to conduct any business which comes to the attention of the Secretary of the LCSB.

Section VII. Amendments or Revisions of the Essentials for Approval of Examining Boards in Medical Specialties.

Amendments or revisions of the Essentials must be approved by the ABMS and the AMA House of Delegates. Those amendments or revisions which have been approved by two-thirds of the LCSB shall be transmitted by the Secretary to these parent groups for consideration and vote. Changes in the Essentials shall take effect on approval of both the ABMS and the AMA House of Delegates.

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SELF-DESIGNATED BOARDS

Information exists in the ABMS files on the following self-designated boards. They are called "American Board of ______________" unless otherwise designated, and each purports to certify physicians.

Abdominal Surgeons
Acupuncture Medicine
Addictionology
Aesthetic Plastic Surgery
Alcoholism & Other Drug Dependencies (AMSAODD)
Algology (Chronic Pain)
Ambulatory Anesthesia
Anthroscopy
Bariatric Medicine
Bionic Psychology
Bloodless Medicine & Surgery
Chelation Therapy
Chemical Dependence
Clinical Chemistry
Clinical Ecology
Clinical Neurology
Clinical Neurophysiology
Clinical Neurosurgery
Clinical Nutrition
Clinical Orthopaedic Surgery
Clinical Pharmacology
Clinical Polysomnography
Clinical Psychiatry
Clinical Psychology
Clinical Toxicology
Cosmetic Plastic Surgery
Cosmetic Surgery
Council of Non-Board Certified Physicians
Critical Care in Medicine & Surgery
Disability Evaluating Physicians
Electrodiagnostic Medicine
Electroencephalography
Electromyography and Electrodiagnosis
Environmental Medicine
Epidemiology (College)
Facial Cosmetic Surgery
Facial Plastic Surgery
Forensic Psychiatry
Forensic Toxicology

Hand Surgery
Head, Facial & Neck Pain & TMJ Orthopedics
Health Physics
Homeotherapeutics
Hypnotic Anesthesiology, National Board for
Industrial Medicine & Surgery
Insurance Medicine
Int'l. Cosmetic & Plastic Facial Reconstr. Stds.
Interventional Radiology
Laser Surgery
Law in Medicine
Malpractice Physicians
Maxillofacial Surgeons
Medical Accreditation (American Federation for)
Medical Genetics
Medical Hypnosis
Medical Laboratory Immunology
Medical-Legal Analysis of Medicine & Surgery
Medical Legal & Workers Compensation Medicine & Surgery
Medical Legal Consultants
Medical Microbiology
Medical Preventics (Academy)
Medical Toxicology
Medical Psychotherapists
Microbiology (Medical Microbiology)
Military Medicine
Neurologic & Orthopaedic Dental Medicine & Surgery
Neurological & Orthopaedic Medicine
Neurological & Orthopaedic Surgery
Neurological Microsurgery
Neuro-Orthop. Dental Medicine & Surgery
Neuro-Orthop Electrodiagnosis
Neuro-Orthop. Laser Surgery
Neuro-Orthop. Psychiatry
Neuro-Orthop. Thor. Medicine/Surgery
Nutrition
Orthopaedic Microneurosurgery
Otorhinolaryngology
Pain Management (American Academy of)
Pain Management Specialties
Pain Medicine
Percutaneous Diskectomy
Plastic Esthetic Surgeons
Prison Medicine
Psychiatric Medicine
Psychiatry (American National Board of)
Psychoanlaysis (American Examining Board in)
Psychological Medicine (International)

List of Self-Designated Boards
October 31, 1988
Page 3

Quality Assurance and Utilization Review
Radiology and Medical Imaging
Rheumatologic Surgery
Rheumatological and Reconstructive Medicine
Ringside Medicine & Surgery
Skin Specialists
Spinal Cord Injury
Spinal Surgery
Sports Medicine/Surgery
Toxicology
Trauma Surgery
Traumatologic Medicine & Surgery
Tropical Medicine
Ultrasound Technology
Urologic Allied Health Professionals

Total - 102

AMERICAN BOARD OF
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Serving the Specialty of Otolaryngology – Head and Neck Surgery
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March 8, 1989

Frank Papineau
Investigative Staff Member
Subcommittee on Regulation
B-363, House Offices
Washington, DC 20515

Dear Mr. Papineau:

It was a pleasure to talk with you on the telephone last week. In follow-up to our discussion I am pleased to provide the following information about the American Board of Otolaryngology and what is expected of candidates who become certified by the American Board of Otolaryngology.

The Americen Board of Otolaryngology (ABO) serves the specialty of otolaryngology-head and neck surgery. As such, candidates who present themselves for certification by the board must have completed an ACGME accredited residency program in otolaryngology which must have included at least one year of general surgery and three years of formal otolaryngology training, plus one additional year in an accredited residency program. Throughout the United States today, most otolaryngology residency programs include one year of general surgery and four years of otolaryngology. However, a substantial number of programs include two years of general surgery and four years of otolaryngology. All programs require formal training in facial plastic and reconstructive surgery. Enclosed is a copy of the published essentials for training in the specialty.

As you will see from our Booklet of Information (enclosed), candidates are expected to have had training in facial plastic and reconstructive surgery, and they are examined in that area. Facial plastic and reconstructive surgery is an integral part of the required training in the specialty and has long been a component part of the specialty. Not all training programs are uniform. However, the basic principles in that area of our specialty are expected to have been mastered by the residents who complete training.

Each candidate who applies for certification must complete an operative report. As you will see from the enclosed copy of that operative report several facial plastic and reconstructive operations are listed. In 1987, 277 candidates applied for the examination, who had completed residency, and were taking the examination for the first time. Those candidates reported that they had performed as surgeon an average of 167 facial plastic and reconstructive procedures in the various categories listed on the enclosed operative report form. In addition to that, they reported that they assisted in an average of 72 facial plastic and reconstructive procedures.

Between 20 and 25 percent of our examination consists of questions, the content of which is in the facial plastic and reconstructive area. I think from the foregoing you can see that considerable emphasis is placed on this section of our specialty. You will also see from the Booklet of Information that the Board does not believe that the certification examination represents a license to practice medicine. It is a basic measure of the knowledge base of those individuals who have completed the requisite training. Therefore, it is a reflection of their overall competence in the specialty. The ABO does not credential individuals as to their capability to perform a given operation, Such credentialing is the responsibility of individual hospital credentialing committees.

As I mentioned to you on the phone, there are many areas of medicine which overlap with another specialty. For example, in hand surgery there are at least three specialties that train individuals who would be considered qualified to perform hand surgery: general surgery, orthopaedic surgery, and plastic surgery. Probably most of the hand surgeons produced today come out of orthopaedic surgery training programs; but, nevertheless, plastic surgery and general surgery programs prepare their residents in that area also.

Family Practice expects their residents who complete training in that specialty to be qualified in obstetrics and also to a limited extent colonoscopy. These two areas obviously overlap with the specialties of obstetrics and gynecology and with the sub-specialty of gastroenterology in internal medicine. In like manner, in urology there are a number of plastic procedures in the genito-urinary system, as well as other procedures in the genito-urinary system that would overlap with what is expected of individuals trained in general plastic surgery or in obstetrics and gynecology.

Lastly, as I mentioned to you the overlap in head and neck surgery, particularly in head and neck oncology, that exists today, is a result of the training in that field that is expected of otolaryngologist-head and neck surgeons, general surgeons, and plastic surgeons.

On one final point, the ABO does not endorse "out of field" surgery practices of its diplomates; however, the medical licensure acts of the various states give wide latitude to licensed physicians and allow for practice activity irrespective of specialty.

From the foregoing, you can see that it is quite logical that there would be an overlap in facial plastic and reconstructive surgery with otolaryngology-head and neck surgery and plastic surgery. Please let me know if there is any further information I can provide for you.

Sincerely yours,

Bobby R. Alford

Bobby R. Alford, M.D.
Executive Vice President

BRA/nb
3 Enclosures

Policy Statement

American Academy of Otolaryngology-
Head and Neck Surgery, Inc.

1101 Vermont Ave., N.W. • Suite 302 • Washington, D.C. 20005 • 202/289-4607

The Scope of Otolaryngology-Head and Neck Surgery

The American Academy of Otolaryngology-Head and Neck Surgery agrees with the policy of the American Medical Association that surgeons should be allowed to do all procedures for which they are qualified by training and experience. Otolaryngologists are, by training, regional physicians and surgeons of the head and neck. Included within the field are those measures associated with the restoration or improvement of form and function of structures of the head and neck. This may require harvesting of tissues from other anatomical areas.

Surgery performed in anatomical areas outside the head and neck not primarily relating to the treatment of conditions involving the head and neck is not considered to be within the scope of otolaryngology-head and neck surgery.

Adopted 5/19/84

ERR

MAY 26, 1989

CONGRESSIONAL QUARTERLY'S
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POLICING THE PROFESSIONS

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Your doctor may say he's "board-certified," but that doesn't mean the AMA recognizes his certification. Anyone can set up such "boards," and some of them don't require any special training.

LAWYERS JUDGING LAWYERS *297*
In almost every state the courts have said it is unconstitutional for anyone but lawyers to regulate lawyers.

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It's now common for non-lawyers to serve on legal disciplinary panels, but some critics say the reforms won't work unless lawyers are excluded from the process altogether.

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POLICING THE PROFESSIONS

by Sarah Glazer

When doctors or lawyers do something wrong, their state medical boards or state bar associations are supposed to discipline them. But even those who are guilty of serious misconduct or negligence often get off with only a slap on the wrist — or no punishment at all. Critics say the current system of self-policing, which has characterized the medical and legal professions since the late 19th century, does not protect consumers from incompetent or unscrupulous professionals and should be abolished.

Consumers' attitudes toward the "learned professions" of law and medicine have traditionally been a mix of trust and suspicion: Because we trust doctors and lawyers with our lives and our fortunes, we believe they must be ethically superior. But because it is difficult for the public to judge their competence, we are unable to hold them as accountable for their actions as ordinary merchants.

This double-edged view permeates the debate over who should regulate the professions. Many doctors and lawyers support the current system, which gives professionals the responsibility of policing themselves. They contend that only their peers have the specialized knowledge needed to judge their conduct and performance and to protect the public from incompetence and negligence.

But critics argue that the public would be better served if the power to regulate the professions were transferred to a public agency in which no member (or at most a minority of members) belongs to the profession being regulated. They say professionals sitting in judgment on their colleagues can't be trusted to act objectively. A lawyer who sins "is generally somebody's friend who is basically a good guy who has 'gone bad' temporarily," says California State Bar Governor Richard Annotico. "And who in hell enjoys being an executioner?"[1]

Defenders of the current system say the primary motivation for establishing the self-policing system was to protect the public from charlatans. Members of the legal and medical professions should be held to higher ethical standards than the average businessman, they say, and the responsibility for enforcing those higher standards, which are embodied in the ethical codes of state bar associations and state medical boards, should be retained by the professionals themselves. (*See box, right.*)

Professionals are special, says Michael Josephson, a former professor of law at Loyola University in Los Angeles and now president of the Josephson Institute for the Advancement of Ethics, a non-profit organization in Marina del Rey, Calif. Unlike "the fellow selling the normal product," professionals are trying to do more than just "maximize profits": They're trying to help people. And, says Josephson, that creates "a fiduciary relationship" between the professional and his client that's different from other occupations.

"That's a lovely fiction," counters Kay A. Ostberg, deputy director of HALT, a national consumer group based in Washington, D.C., that advocates legal reform. "The fact is that lawyering is a business. Anyone who works in a law firm for 10 minutes can tell you that. All anyone wants to know is, 'What's the case worth?' . . . If you go into a lawyer with that additional trust, you're a lot less likely to be happy when you go out than if you go in with the attitude that you're approaching a business."

In recent years, the government has started treating the professions more like other businesses. Reacting to the charge that self-regulated professions restrict competition, the Federal Trade Commission (FTC) has taken a number of steps since the 1970s to make the professions more competitive. Ironically, many of these actions are now being criticized for removing important consumer protections — protections the professions had imposed upon themselves through their ethical codes.

Until 1975, doctors and lawyers had assumed that legal and medical services could not be considered "commerce" under the definition of the Sherman Antitrust Act. But in 1975 the Supreme Court, in *Goldfarb v. Virginia State Bar*, brought the learned professions within the reach of federal antitrust laws; it ruled that lawyers and bar associations violate federal antitrust laws against price-fixing when they require lawyers to adhere to minimum-fee schedules in charging for their services.

In this changed regulatory climate, the FTC in 1975 filed a complaint against the American Medical Association and two affiliated Connecticut medical societies, charging that the societies were conspiring to restrain trade through their ethical codes. The FTC complaint focused on the codes' admonition that physicians should not solicit patients through such means as advertising.* The FTC's position was affirmed by a divided Supreme Court in 1982, in *American Medical Association, et al., v. Federal Trade Commission.* The Supreme Court action affirmed a 2nd U.S. Circuit Court of Appeals decision upholding the FTC's charge that the medical societies had violated federal prohibitions against restraint of trade.

[illegible]

Today, some are questioning whether the FTC, through its activism in the professions, has neglected its equally important responsibility for protecting consumers against fraud. An ongoing congressional investigation of cosmetic surgery advertising has blamed the FTC's 1982 court victory for throwing open the regulatory door to misleading advertising. "Not only did it send the message that the FTC would *not* prohibit the peddling of medicine, *it made it virtually impossible for the medical profession to police its own to ensure ethical standards and quality care,*" charges a staff memo by the House Small Business Subcommittee on Regulation, Business Opportunities and Energy.[2]

"My sense is the Federal Trade Commission has gone way overboard in the last few years in terms of its calculations of what is appropriate advertising," Rep. Ron Wyden, D-Ore., chairman of the Small Business Subcommittee, said in an interview. "They seem to think that medical advertising is not very much different than selling blenders or Hostess Twinkies." Wyden says the FTC has not aggressively pursued some "awfully far-fetched claims," and "a lot of hucksters have been able to exploit the FTC's slumbering behavior."

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*Although the ethical codes promulgated by the AMA and the local medical societies do not carry the force of law, they had been widely observed with respect to advertising.

Richard Kelly, assistant director of the FTC's Division of Service Industry Practices, says the commission is currently "looking at whether we need to do casework in the specific area of cosmetic surgery practices by physicians." But FTC officials maintain that state medical boards should be playing the principal role in tracking down incompetent physicians. The FTC's role, they say, is limited to preventing false and misleading advertising. "[T]he solution [to the problem of misleading advertising] is to insure [that consumers] have access to information and have the government stand there and say that if [physicians] give false information, we're going to prosecute them," says Jeffrey Zuckerman, director of the FTC's Bureau of Competition.

Doctors judging doctors: Does the system work?

Joyce Palso of Santa Ana, Calif., was among those who were enticed by advertisements for cosmetic surgery. "[I]t all sounded so simple," Palso told Wyden's subcommittee. "I decided I could stand a tuck here and there to improve my looks and perhaps look younger. The ads almost sounded like going to get a tooth filled — go in in the morning . . . go home in the afternoon."[3] Palso decided to have a "tummy tuck" to flatten her stomach. But what should have been relatively simple surgery turned into a nightmare of life-threatening infections and permanent dependence on an artificial heart valve. And it happened even though, before the operation, Palso had done everything she could think of to check her doctor's medical credentials. It seems that none of the government or medical authorities she contacted warned her that Dr. James Dean had 11 malpractice suits filed against him at the time of her operation.

Recent examinations of the California and Maryland state disciplinary systems support the impression that incompetent physicians are seldom plucked from the medical profession as soon as they are detected. In both states, only a tiny minority of consumer complaints are acted upon, and only a fraction of those lead to disciplinary action against the doctor. Those complaints that do lead to penalties take years to reach a conclusion. During that time, the accused doctor continues to practice, and any complaints against him remain secret. What's more, very few of the disciplinary actions that are taken against doctors are for incompetence or negligence, presumably the primary concern of any patient.

A 50-state survey undertaken in 1986 by the inspector general of the Health and Human Services Department found similar trends across the nation. Inspector General Richard P. Kusserow discovered that it was not uncommon for state boards to have backlogs of hundreds of pending cases while overloaded investigators struggled to handle their current caseloads. He also found that cases involving penalties for physician incompetence were relatively rare throughout the states. Over-prescribing drugs to patients, drug abuse and alcohol abuse accounted for about three-fourths of the disciplinary actions taken by state boards. "The minimal response in the area of physician incompetency is placing boards in an increasingly untenable position as the incidence of malpractice cases and the public concern about the implications of these cases increase," Kusserow noted.[4] He blamed the states' poor track record on three factors — the length and cost of cases involving incompetence, a tough legal burden of proof in many states that requires "clear and convincing" evidence of incompetence, and the variation among physicians themselves as to what constitutes acceptable practice.

When a Maryland gynecologist, Dr. Kook Ben Ahn, was convicted of raping a patient on the examining table in 1986, the Maryland Commission on Medical Discipline did not revoke the doctor's medical license. Instead, the commission voted to allow him to continue practicing gynecology as long as a chaperone was present during physical examinations. Last year, he was still practicing in the state. His case inspired a *Washington Post* examination of the Maryland disciplinary system. The *Post* discovered that doctors in Maryland rarely lose their licenses even when they are found by the commission to be incompetent or are convicted of crimes of moral turpitude — and even, as in the case of Dr. Ahn, when the crime of moral turpitude is directly related to the doctor's medical practice.

Under Maryland state law, as in most states, the state medical board is composed mainly of physicians. It has the power to revoke a license to practice or to impose lesser penalties on a physician for committing a violation listed in state law. These lesser penalties, which are the most frequent types of penalties imposed in most states, include private letters of reprimand and plea bargain-type agreements with the physician, many of which remain confidential. The grounds for disciplining a doctor vary from state to state. In the case of Maryland, crimes of moral turpitude like rape are within the board's scope of discipline.* But the board

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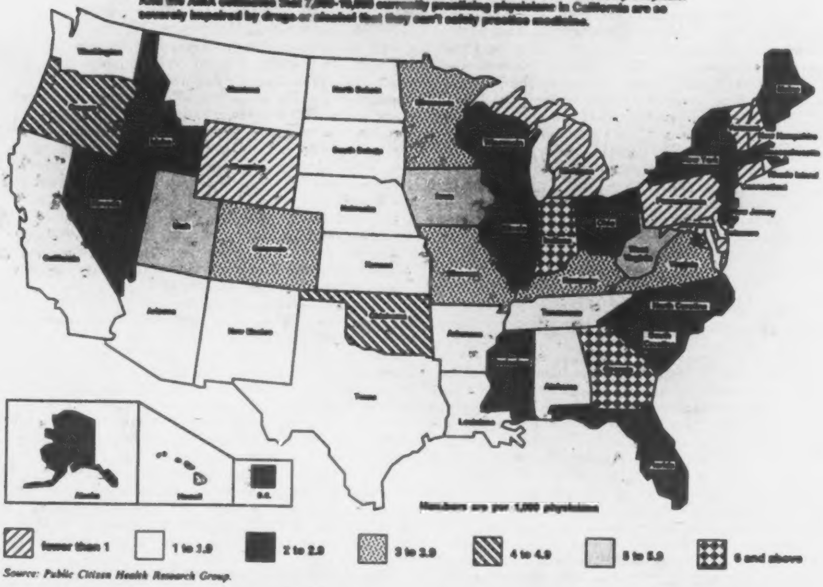
*Under some state laws, conviction for a felony of any kind is grounds for discipline. Under other state statutes, conviction for a felony is grounds for discipline only if it bears directly on the physician's ability to practice medicine.

Disciplining the Doctors

This map shows how frequently serious disciplinary actions were taken by state medical boards per 1,000 physicians in 1988. Critics say the relative handful of doctors being disciplined is trivial in comparison with the number judged incompetent by other measures, such as malpractice awards or suspension of hospital privileges. For example, in 1987-88 only 42 of California's 70,000 physicians had their licenses suspended or revoked, according to a study by Robert C. Fellmeth, director of the University of San Diego's Center for Public Interest Law. During that same period, however, 715 physicians were found guilty of malpractice or agreed to settlements in excess of $30,000; 249 had their privileges suspended or revoked by hospitals. And the AMA estimates that 7,000-10,000 currently practicing physicians in California are so severely impaired by drugs or alcohol that they can't safely practice medicine.



Source: Public Citizen Health Research Group.

usually has wide latitude in deciding what the penalties shall be. Although some states, like Maryland, allow their medical licensing boards to order an immediate emergency suspension of a license, this power is rarely exercised.

Of the Maryland commission's 157 formal disciplinary actions over the past two decades, only 18 have resulted in revoked licenses. Only two of those 18 physicians had their licenses revoked on grounds related solely to poor patient care. Two dozen other physicians whom the commission found incompetent were allowed to continue to practice. The *Post* suggested that Maryland's system might be worse than other states' because of its lack of independent investigators and its total reliance on volunteer doctors from local medical societies to look into complaints. In addition, the newspaper noted, the Maryland board may not be as objective as it ought to be because the board retains strong ties to the state medical society. The state medical society is responsible for nominating a majority of the commission's 11 members.[9]

Yet the handling of complaints against doctors appears equally scandalous in California, which consumer activists praised in the mid-1970s for passing legislation to strengthen doctor discipline. According to a study released last month, "the system cannot and does not protect Californians from incompetent medical practice. It is effectively moribund."[10]

The study was conducted by Robert C. Fellmeth, director of the University of San Diego's Center for Public Interest Law and professor of law at the university. In 1987, Fellmeth was appointed by the state attorney general to conduct a similar study of California's legal disciplinary system; that study led to a revamping of the system for disciplining lawyers. (*See p. 300.*) According to Fellmeth's report on the medical discipline system, more than 97 percent of complaints that are valid on their face never see the light of day.

"The attitude of those making these decisions is openly solicitous of the physician," the report charges. Consumer complaints are handled by California's Board of Medical Quality Assurance, the state board responsible for granting and revoking doctors' licenses. Compared with the estimated 50,000 to 80,000 phone complaints against physicians received by the board annually, only 42 physicians had their licenses suspended or revoked in 1987-88. Incompetence or gross negligence was the cause for only 12 of those cases; the rest had their licenses revoked for a variety of other reasons ranging from criminal convictions to drug or alcohol abuse.

"The [medical] profession would like nothing better than to police itself, but we do not have the tools with which to do it," says AMA Vice President Dr. James S. Todd.

According to Fellmeth, the handful of doctors being disciplined is trivial, in comparison with the hundreds judged incompetent by other measures, such as malpractice awards and suspension of hospital privileges. Fellmeth blames the medical profession's control of the board — a majority must be physicians under state law — as the root cause of the problem. "I find the appointment of someone with a direct, current, vested profit stake in the industry regulated to be unconstitutional and grossly improper," he said in an interview. He proposes that discipline cases be screened in the preliminary stage by a state agency consisting entirely of non-doctor members. Penalties would be meted out by a special administrative court. Fellmeth argues that the need for medical expertise could be handled by having the court consult with panels of medical experts in the case under consideration. He contends that the expertise of doctors on most state medical boards is overrated since most issues involve narrow specialties. "If you're a proctologist, is it going to help you decide the competence of a neurosurgeon?" he asks.

Doctors serving on a hospital's peer-review panel can revoke a doctor's privileges. But Fellmeth believes this peer-review system is both weak and unfair. It's weak because in a town with several hospitals an incompetent doctor can just go to another hospital. It's unfair because in a town with one hospital a doctor can be driven out of business by competitors jealous of the accused doctor's patient income.[*]

Confronted with charges that the medical profession is a bunch of foxes guarding the henhouse, AMA Vice President Dr. James S. Todd counters that doctors, as a profession, do not have the power to police themselves, as consumer critics contend. "The [medical] profession would like nothing better than to police itself, but we do not have the tools with which to do it," he says. Most doctors can only exert direct pressure on an incompetent colleague through their state or local medical societies, which are voluntary dues-paying associations of doctors with no legal power, he points out. The power of these societies is limited to the club of moral embarrassment: They can expel the physician from the society — an action that is rarely made public — but cannot suspend the doctor's license to practice. Although state medical societies usually recommend a list of eligible physicians to the governor or state official responsible for appointing the state licensing board, "often it is ignored for political reasons." Generally, the strongest action the local medical society can take is to report an errant physician to the state licensing boards, "most of which are under-funded, under-staffed and really can't do what they're empowered to do," Todd says.

Even the AMA is reconsidering whether doctors should dominate state medical boards. In connection with a proposal put forward last January for resolving medical malpractice suits outside the courts, the AMA recommended that state medical boards be reconstituted to pass judgment on medical liability claims. However, doctors would no longer make up

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[*] The unfairness issue was at the nub of a Supreme Court case, *Patrick v. Burget*, decided last May. The case got its start when Dr. Timothy A. Patrick of Astoria, Ore., filed a suit asserting that physicians sitting on the peer-review panel of the town's only hospital conspired to put him out of business. In upholding a $2.2 million suit awarded to Patrick, the court declared that doctors on such hospital panels were not immune from antitrust suits. Initially, the suit had raised the specter that doctors would be reluctant to report incompetent or negligent colleagues to a peer-review panel for fear of being sued. However, a law passed by Congress in response to the Patrick suit, the Health Quality Improvement Act of 1986 (PL 99-660), provides that doctors who serve on peer-review teams or who report information to them will be immune from liability if their action is taken "in the reasonable belief that [it] was in the furtherance of quality health care."

Economics and the Move Toward Self-Licensing

Critics of self-regulation of the professions say the tradition grew out of a self-interested desire to limit the number of people in the professions. "[A]nybody who would conclude after looking at [the history of regulation of the professions] that economic incentives haven't played a part must be assuming that the people involved were saints," says Charles W. Wolfram, professor of law at Cornell Law School and a prominent critic of self-regulation in the legal profession.

Until the late 19th century, doctors and lawyers alike struggled to achieve prestige in a market that made few distinctions between those who had training and those who did not. To limit entry into their professions, and thus restrict competition, doctors and lawyers encouraged the states to pass laws that required a license to practice a profession.

By 1898, all states and territories of the United States except for Alaska had passed laws requiring medical doctors to obtain licenses to practice. The power to grant those licenses was given to state medical boards. This system of medical regulation remains essentially intact today.

Lawyers also made a concerted effort to gain control over their profession in the late 19th century. Until then, American courts and legislatures had shared control over the legal profession. But with the creation of powerful bar associations in the 1870s, first on a local and then on a national level, the legal profession established the means to limit the number of lawyers and to regulate itself.

When lawyers attempted to codify new entry standards in the law, however, they found that state legislatures were not always cooperative. Judges tended to be more receptive. To justify taking regulation of lawyers away from the legislatures, courts turned to two legal arguments. First they argued that because of the constitutionally mandated separation of powers among the three branches of government, only the judiciary had the right to regulate its members. The courts also argued that lawyers were "officers of the court," a term of obscure origin derived from early English history, and were therefore responsible to the court for their ethical behavior.†

The legal requirements that certain kinds of work be performed only by lawyers dates from the 1930s, when lawyers were particularly pinched by competition from outsiders in such areas as drawing up real-estate papers. During the Depression, the American Bar Association for the first time formed a committee to prohibit the "unauthorized practice of law." This committee kept the issue before the courts. Subsequently, case law helped to define legal practice broadly, thus preventing competition from outside the profession. By 1938, for example, case law provided that the preparation of real-estate documents constituted the practice of law. Today, although the definition of unauthorized practice varies from location to location, the unauthorized practice of law is prohibited by statute or by case law in every state.

Doctors and lawyers are not the only ones who have recognized the advantages of a professional licensing system; practically every organized occupational group in the United States has tried at one time or another to break into the ranks of licensed professionals.†† In 1955, for example, a bill was introduced in the California Assembly that would have required the licensing of grass-cutters as "maintenance gardeners." Anyone mowing a lawn for pay without a license would have been subject to a $500 fine and six months in jail. The bill did not pass, but today more than 30 occupational groups are licensed in California. Other states license dozens of groups. In addition to the obvious professions, at least one state licenses private detectives, egg graders, electricians, elevator inspectors, guide-dog trainers, horseshoers, librarians, manicurists, masseurs, milk certifiers, mine inspectors, motor-vehicle dealers, oculists, pest controllers, plumbers, shorthand reporters, social workers, watchmakers, well-drillers and yacht-brokers. Other groups will no doubt continue to try to achieve the status and perceived benefits that licensing brings.

† The term "officer of the court" apparently dates from the 13th century, when litigants often hired court employees who were experts in procedure to stand in for them and represent their interests.

†† Jethro K. Lieberman, "The Tyranny of the Experts: How Professionals are Closing the Open Society," in The Legal Profession: Responsibility and Regulation, edited by Geoffrey C. Hazard, Jr. and Deborah L. Rhode (1988), pp. 113-114.

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the majority of members on the new boards. AMA senior attorney Martin J. Hatlie said the committee rejected majority composition "because of the danger that you will have cronyism ... but is recommending that there be a minority of physicians on the board so you will have the medical expertise you need." A bill modeled on the AMA proposal was introduced in the Vermont Legislature this year and is expected to be proposed in the Utah Legislature next year, according to Hatlie.[7] *

Dr. Sidney M. Wolfe, co-founder with Ralph Nader of the Public Citizen Health Research Group in Washington, D.C., says that even a few doctors sitting on a state disciplinary board is too many. In many states, he argues, "it is already 'too much' to expect doctors on state boards to discipline seriously their fellow doctors," let alone pass judgment on malpractice suits, as the AMA has proposed. Rather than abandoning the current jury system of deciding malpractice suits, Wolfe's group proposes to put teeth in the state discipline systems by increasing the physician licensing fees that fund the boards, granting boards subpoena power to obtain evidence against accused doctors, granting boards emergency powers to suspend a doctor's license and requiring periodic recertification of doctors based on written exams and audits of doctors' performance.[8]

Everyone seems to agree that state medical boards have a funding problem. In most states, medical board revenues come from the fees imposed on physicians to obtain or renew a license. According to Inspector General Kusserow, these fees have barely kept pace with inflation. In addition, many state boards are allowed to keep only a portion of the fee money collected, with the remainder going into the state treasury.

Checking out doctors' credentials

It is extremely difficult for a patient to check out a doctor's credentials. For one thing, as Joyce Palso learned, state medical boards make it a policy not to inform a potential patient of pending complaints or suits against a doctor. Before Palso went to Dr. Dean, she called the California Board of Medical Quality Assurance to see whether it had any information that would lead her to question the cosmetic surgeon's competence. She was told there was "nothing on him." Only after her disastrous "tummy tuck" operation did an investigator from the board inform Palso that Dean had 11 malpractice suits filed against him at the time of her call. As was its policy, the board didn't give her the information earlier, the investigator told her, because the doctor had not been proved guilty. "It takes sometimes four and one-half years to get a trial date for medical malpractice in California, so does that mean in the meantime that these guys can keep cutting on people?" Palso asked a congressional subcommittee in April. She noted that over the four-year period in which the doctor was investigated, one patient died from the same kinds of infections that Palso suffered.[9] (Dean's license was revoked in 1987.)

The policy of protecting a doctor's confidentiality stems from doctors' tendency to treat accused colleagues much like patients, says Robert M. Veatch, professor of medical ethics at Georgetown University's Kennedy Institute of Ethics in Washington, D.C. "The negligent physician becomes ... somebody who's gone wrong and the board's primary role is therapeutic: 'Let's make sure it doesn't happen again.' So they bend over backwards to do things in a therapeutic mode, which would include respecting confidentiality."

Other kinds of attempts to check out a doctor's credentials often yield misleading results. Joyce Palso found that out the hard way, too. Palso knew it was advisable to seek a "board-certified" specialist, and she was told that Dean was a member of the Board of Cosmetic Surgeons. What Palso didn't know is that anyone can organize such a "board" and that many of them invite doctors to participate without requiring any special training. Only 23 boards — those that are members of the American Board of Medical Specialties in Evanston, Ill. — are recognized by the AMA. According to the specialties board, physicians who wish to receive certificates from these boards must meet rigorous requirements to prove their competence in a specialty. The specialties board notes there are at least 102 self-designated boards without its stamp of approval and says it has no information about such boards' standards or requirements. The Board of Cosmetic Surgeons to which Palso's doctor belonged was self-designated and did not have AMA recognition.

Jeffrey Zuckerman of the FTC's Bureau of Competition says the validity of a claim to a specialty is something for consumers to judge after reading competing claims in the ads. He also questions whether the government should recognize some medical boards as being more credible than others. "We should be very reluctant to let the government grant a monopoly to some group of private practitioners, because history suggests as soon as they receive that monopoly, they decide: 'No one should join our group, and we'll raise our prices and tell everyone they're much safer that way.'"

More honest advertising, more knowledgeable consumers — even stricter discipline — may not be enough. Another roadblock facing the inquiring consumer is the ability of a doctor who has had his license removed by one state to move his practice to another state without any record of discipline following him. Patients are not the only ones who have trouble tracking incompetent doctors who jump from state to state. According to the AMA's Todd, "There is no central repository" of data on disciplined physicians. "The best the hospital can do today is get the information from an individual physician, check with the county or state medical society and check with the state licensing board to see if this physician is licensed or has been disciplined." In addition, because lesser reprimands may be made under the agreement that they remain confidential, some state boards do not provide such information to the state to which a disciplined physician has moved.

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*Nearly all state medical boards now have at least one or two non-physician members; one-half had no lay members in 1965.

Congress has attempted to solve this information problem by creating a national mandatory clearinghouse of information on doctors and other health personnel. A data bank supervised by the Department of Health and Human Services is scheduled to start operating by the end of September. Under the Health Care Quality Improvement Act of 1986, each state licensing board is required to report any penalties it imposes on doctors to the bank. Hospitals that restrict the clinical privileges of doctors are required to report such information to the state board, which must report it to the national data bank. In addition, the law requires that each hospital request information from the data bank when a physician applies for clinical privileges and that the hospital check the data bank every two years for any new information concerning physicians on its medical staff.

State licensing boards and medical societies respond to complaints about their disciplinary track records by arguing that the FTC and the courts have tied their hands in self-policing efforts. Whether the threat of FTC action is real or imaginary, the effect seems to be the same: reluctance to take strong disciplinary action against doctors. Edward B. Hirshfeld, associate general counsel at the AMA in Chicago, says the removal of the antitrust exemption for doctors in the 1970s "caused a loss of interest among medical societies generally to strengthen observance of codes of ethics. . . . The psychological tendency is to avoid the whole subject."

Lawyers regulating lawyers: A tradition entrenched in law

Like doctors, lawyers are regulated by their brethren, but more so. What makes lawyers different from doctors — and from every other profession — is that in almost every state the courts have said it is unconstitutional for anyone but lawyers to regulate lawyers. The 50 state supreme courts have been nearly unanimous in declaring that regulating the legal profession is inherently part of the judicial power of the government, to be exercised by the state supreme court as head of that branch of government.*

This so-called "inherent powers" doctrine permits the legal profession to ward off any attempt by a state legislature or an administrative agency to police it. Lawyers — and only lawyers — draft the ethical codes by which lawyers must abide. Lawyers also draft the procedural rules governing how a lawyer who violates the code is to be disciplined. Both the codes and the rules, which are generally adopted by the state bar association, have the force of law in every state. Lawyers dominate the operation of the disciplinary system as well. Consumer complaints are received in 33 states by a branch of the state bar association, in the remaining states by an independent state agency under the aegis of the state's highest court. Complaints are handled by attorneys at every stage of the process and then passed up the line to the state's highest court for a final determination. And lawyers keep out the competition by defining the unauthorized practice of law and by defining those areas that only lawyers may touch.

Despite the widespread acceptance of the inherent-powers claim, Cornell law Professor Charles W. Wolfram, author of the legal textbook, *Modern Legal Ethics*, finds it unconvincing. "I think it's a doctrine that's been much too broadly applied. The U.S. Supreme Court has never spoken on it. I doubt they would ever adopt as broad an inherent-powers doctrine as many of the states have."

Consumers criticize self-regulation as ineffective and inherently unfair. "It's slow, it's lenient and it is an inhospitable process for consumers," says Kay Ostberg of HALT. "We think consumers of legal services need the same kind of consumer protection that other consumers get when they're dealing with other kinds of services and businesses." Ostberg condemns the inherent-powers argument as "a maneuver on the part of lawyers who felt pretty confident that the lawyers and judges were more likely to be their friends than the legislature. What's happened, in effect, is that the courts have turned around and handed it to the bar associations to do the work of licensing and enforcement of discipline. That's self-regulation, and we feel that's the fatal flaw that led to all the problems we see with discipline."

As evidence that the system is not working, Ostberg points to the small percentage of consumer complaints that result in penalties of any kind. Of the 90,000 complaints reported by the states to the American Bar Association in 1987 (the most recent year for which statistics are available), 93 percent were dismissed in the initial screening stage and never

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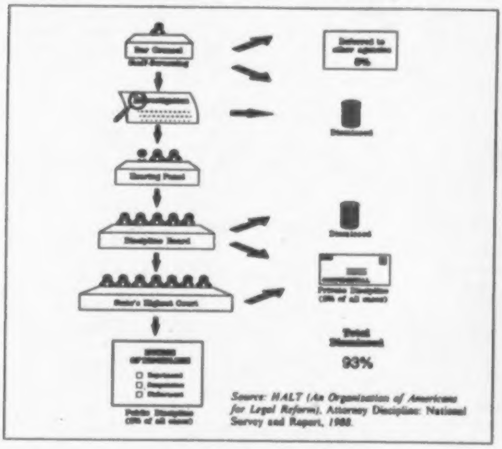
*The courts base their stand on the constitutional right to an independent judiciary branch under the separation-of-powers doctrine. Of the 50 states, only New York's and Oregon's highest courts have not asserted their primary authority to regulate the bar, according to a 1987 survey by the National Center for State Courts in Williamsburg, Va.

Filing Complaints Against Lawyers: How the Process Works



Source: HALT (An Organization of Americans for Legal Reform), Attorney Discipline: National Survey and Report, 1988.

Although each state's legal grievance system operates independently, almost all follow the model shown at left, which was prepared by the legal reform group HALT. The discipline process begins when someone files a complaint with the state's disciplinary agency. In 30 states the disciplinary agency is run by state bar associations. In the remaining states, the disciplinary agency is technically independent, but the state bar has considerable influence over who sits on the disciplinary board, who is hired as bar counsel (the agency director, traditionally a lawyer), how the complaints are processed and what is considered unethical conduct under the state's code of professional responsibility. Complaints can be initiated by clients, judges, other lawyers or the disciplinary board itself. Complaints are screened by the bar counsel's staff to determine whether they allege misconduct under the state's code. Only complaints that survive this initial screening are investigated by a hearing panel. Recommendations of the hearing panel are reviewed by the disciplinary board, which can dismiss or recommend public discipline. Recommendations for public discipline are reviewed by the state's highest court. The court can dismiss the complaint or impose discipline. The typical options for discipline include a public reprimand, a temporary suspension of the lawyer's license to practice or outright disbarment. In most states the lawyer has the right to appeal the court's decision. Less than 5 percent of the complaints received result in public or private disciplinary actions, as shown in the state-by-state chart below.

	Resident Lawyers	Estimated Complaints Received by Agency	Number of Lawyers Privately Disciplined	Number of Lawyers Publicly Disciplined
Alabama	8,500	850	80	20
Alaska	1,978	304	9	1
Arizona	8,221	1,409	73	22
Arkansas	5,600	1,767	15	28
California	97,566	19,458	23	205
Colorado	—	1,041	98	33
Connecticut	—	822	0	36
Delaware	1,287	202	4	3
District of Columbia	—	940†	48	37
Florida	38,000	6,782	92	246
Georgia	15,700	4,275	33	23
Hawaii	3,349	—	30	3
Idaho	2,300	296	15	8
Illinois	44,326	4,886	8	183
Indiana	10,200	1,014	18	27
Iowa	7,000	329	40	29
Kansas	—	578	31	6
Kentucky	7,000	446	22	18
Louisiana	12,400	1,800	—	43
Maine	2,893	355	0††	17
Maryland	—	1,531	14	38
Massachusetts	27,161	1,907	82	37
Michigan	23,097	3,381	127	103
Minnesota	15,894	1,891	106	34
Mississippi	4,085	465	2	26
Missouri	13,571	992	52	15
Montana	—	193	15	2
Nebraska	4,567	301	13	14
Nevada	2,434	437	3	2
New Hampshire	2,364	126	14	8
New Jersey	22,000	830	20	55
New Mexico	3,500	613	21	31
New York	44,709	10,682	214	137
North Carolina	9,725	767	16	21
North Dakota	1,197	144	2	2
Ohio	8,823	4,305	0	50
Oklahoma	8,707	1,583	39	23
Oregon	7,300	910	—	25
Pennsylvania	—	2,901	133	45
Rhode Island	3,200	1,000	4	0
South Carolina	5,432	467	7	12
South Dakota	1,320	89	8	3
Tennessee	10,233	960	100	35
Texas	38,750	5,300	79	130
Utah	4,000	601	61	16
Vermont	1,617	123	4	2
Virginia	13,116	1,000	30	26
Washington	12,307	1,605	23	22
West Virginia	3,241	350	0	7
Wisconsin	10,901	1,119	66	32
Wyoming	1,146	117	8	2
Totals	93,622	44,283	2,002	1,840

† D.C. is unique in that many lawyers are government attorneys. Few complaints about government attorneys are received by the ABA.
†† Not allowed by rules.

Source: American Bar Association.

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made it to a hearing. Only 2 percent resulted in some form of public discipline, such as disbarment. Another 2 percent were subjected to "private discipline," such as a letter of reprimand that remains confidential and is not revealed to potential clients. According to ABA statistics, private discipline is the most common form of discipline meted out by the states. (*See chart, left*) In all but a handful of states, cases that do not make it to a hearing remain secret.* For these cases, which compose 93 percent of complaints nationwide, members of the public do not have the right to be informed of the number of complaints filed against a lawyer, whether a lawyer is being investigated for misconduct or why the agency has dismissed complaints against a lawyer. The justification is that a lawyer should not have his or her reputation besmirched by frivolous charges while they are still being investigated. In most states, the obligation to keep a complaint against a lawyer secret even extends to the complaining client. A client who discusses his complaint with anyone outside the discipline system can be subject to a fine or jail sentence for contempt of court. "It's very intimidating," Chicago HALT director Karen Winfield says of this gag rule. "The fact that it exists causes people not to file a complaint."

As with doctors, consumers protest that the disciplinary committees of state bar associations tend to take an overly sympathetic attitude toward the rehabilitation of an accused lawyer. For example, many state codes have provisions for reducing the penalty because of "mitigating factors," and courts are increasingly making use of this approach. Typical mitigating factors include marital or financial problems, alcoholism and drug abuse. "From the client's perspective, reducing discipline based on these mitigating factors is baffling," says a 1988 HALT report on lawyer discipline. "One can hardly imagine a bank forgiving a teller's theft of thousands of dollars and keeping them on the job based on excuses such as alcoholism, mental disability or willingness to pay it back."[10]

In at least one case, a judge has treated alcoholism as a mitigating factor in reducing a lawyer's sentence for misappropriating a client's funds.[11] ABA attorneys say, though, that mitigating factors are not supposed to be applied to such serious offenses as stealing. "We're not talking about guys who are stealing people's money. If you want one sure-fire way of losing your license, steal your client's funds," says Cassie Dalla Santa, regulation staff attorney with the ABA Standing Committee on Professional Discipline. Mitigating factors would more likely be considered, Dalla Santa says, in the most common types of complaints made against lawyers. "Maybe he's blowing a couple of court deadlines or not returning phone calls."

Lawyers who are publicly disciplined are usually those who have repeatedly neglected the case of one or more clients by failing to file court papers or otherwise ignoring the case. The second largest category of publicly disciplined lawyers is composed of convicted felons, followed by those who "fail to communicate," which generally means the failure to return clients' phone calls. Asked why ignoring a case — labeled by the ABA as "general neglect" — is the most common offense, Dalla Santa explains, "The majority of these complaints are against sole practitioners or small law firms that don't have good computer systems that bounce out dates." Other lawyers say that attorneys may neglect a case if they have a more important or profitable one demanding their attention.

> *"We think consumers of legal services need the same kind of consumer protection that other consumers get when they're dealing with other kinds of services and businesses," says Kay A. Ostberg, deputy director of HALT.*

Clients often find it paradoxical that lawyers are more likely to be disciplined for violating the law — even if the violation is unrelated to their practice of law — than for inadequate service to the client. For example, many states still consider "crimes of moral turpitude" grounds for revoking a lawyer's license even though the ABA in 1983 revised its Model Rules of Professional Conduct to remove the moral-turpitude language from its earlier code. At the time of the change, the ABA explained that the concept "can be construed to include offenses concerning some matters of personal morality, such as adultery . . . that have no specific connection to fitness for the practice of the law." The revised rules recommend that state codes limit their definition of professional misconduct to those criminal acts closely related to a lawyer's duties, such as conduct involving dishonesty, fraud, deceit or misrepresentation.

Deborah L. Rhode, professor of law at Stanford Law School, considers it "somewhat anomalous that most bar disciplinary authorities do not exercise

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*Only Oregon and Washington make this information public, according to HALT's 1988 survey.

jurisdiction over common client grievances, such as fee disputes and 'mere' negligence, although such bodies retain authority to revoke licenses for a variety of matters much more tangentially related to practice."[12]

"Mere" negligence usually refers to individual acts of neglect in a client's case as opposed to the repeated complaints against an attorney that more often catch the attention of overburdened disciplinary committees, and which are classified as "general neglect." "Mere" negligence may range from drafting a will so that huge amounts of taxes must be paid by the client's family to missing the statute of limitations and causing a case to be barred from court. Disciplinary committees argue that there is no need for them to handle these kinds of complaints because they can be pursued with civil malpractice suits. "The reality is very different," counters Rhode, "since it's very expensive and involves hiring another lawyer, which is the last thing that clients who have been burned by one lawyer want to do."

Fee disputes, too, are often put aside by disciplinary committees on the grounds that they fall under state arbitration statutes for handling the fee disputes of businesses generally. Consumers are often surprised to discover that bar disciplinary organizations in many states do not have the authority to make financial restitution to the aggrieved client who wants his money back. To obtain restitution, disciplinary committees usually advise complaining clients to file a malpractice suit against their lawyer. But Karen Winfield, Illinois director of HALT, says she discovered from her own attempt to file such a suit that lawyers are generally reluctant to sue other lawyers. "Lawyers who have in the past sued other lawyers have been harshly punished by fellow lawyers. They lose referrals, they're ostracized socially and they're treated badly by judges."

Reforming the discipline system: Should lawyers be excluded?

Two of the main consumer complaints about the legal-discipline system — the secrecy and the stranglehold by lawyers — are being addressed in reform efforts and proposals in different parts of the country. But consumer activists and some critics of the profession tend to brand many of these efforts as tokenism.

Over the last decade, numerous states have appointed non-lawyer members to panels that serve within their discipline system, and the ABA now recommends that non-lawyers be included. The inclusion of lay appointees once roused strong objections within the legal profession. Some lawyers argued that lay members would be insufficiently familiar with the code of ethics and legal practice to pass judgment on lawyers, while advocates argued they would lend a broadened client perspective. But Wolfram says these appointments have made very little difference in how the system operates. "In no case do non-lawyers constitute any but a small minority," he points out. "They're also dealing with a strange vocabulary and a context they're unsure of."

Just last month a blue-ribbon committee appointed by the Illinois Supreme Court recommended the inclusion of non-lawyers on its preliminary inquiry board and a lifting of secrecy for cases that make it to a hearing.[13] The study was intended to answer questions raised by an FBI sting operation in the Cook County courts known as Operation Greylord. Greylord resulted in the conviction of more than 30 Chicago lawyers and eight judges who routinely proffered or palmed bribes to fix cases ranging from parking violations to armed robberies over a 20-year period.

The committee's recommendation that one non-lawyer be added for every two lawyers on the board that screens cases for hearings "does not solve the problem of lawyer monopoly," in Winfield's view. Its recommendation that complaints be publicized once they are ready for a hearing affects only a small minority of cases, she notes — about 200 of the 5,000 complaints received yearly.

In California, Robert Fellmeth's scathing indictment of the state bar discipline system has stimulated a major revamping in that state aimed at removing control from practicing attorneys.[14] His 1987 report, prepared for the state attorney general, raised conflict-of-interest concerns about California's system. The report noted that a committee dominated by a majority of practicing attorneys was "making a final decision based on a record given to them by another practicing attorney about the discipline of a third practicing attorney." Fellmeth proposed that the volunteer committee of practicing attorneys — the most common type of forum for deciding legal complaints in the states — be replaced by a panel of judges who hear legal-discipline cases on a full-time basis. Fellmeth argues that full-time judges will be more objective in their treatment of cases than volunteer attorneys. The new system recommended by Fellmeth is to go into effect in California by this September.

Some critics say the California reforms are unsatisfactory because the system remains within the jurisdiction of the courts. The installation of judges in place of attorneys is not a significant change, says Wolfram. "I think an economist or a sociologist would wonder, given all the inter-ties between lawyers and judges, if judges really are the most objective public officials to be regulating their brothers and sisters."

Arguing that the ultimate solution is to take consumer grievances out of the hands of lawyers, HALT is supporting the creation of an entirely new consumer-protection agency for legal services at the state level, as proposed in a bill (SB 916) introduced in the Illinois Legislature April 7. The proposed Illinois agency, the

Should Accountants Charge Contingent Fees?

Doctors and lawyers are not the only professionals concerned about commercial pressures on their profession. Accountants, too, are worried about attempts to make their profession more competitive.

At issue is whether accountants should be allowed to charge contingent fees, which are based on the amount of money the accountant saves the client. Traditionally such fees have been prohibited by the profession's ethical code on the grounds that profit concerns should not influence professional objectivity unduly.

But under a 1988 consent agreement with the Federal Trade Commission, the American Institute of Certified Public Accountants has agreed that it will no longer declare contingent fees to be unethical. The commission is expected to issue a final consent order on the issue following a public comment period, which closes June 5, 1989.

Jeffrey Zuckerman, director of the FTC's Bureau of Competition, says the profession's current practice of charging fixed or hourly fees has the effect of denying service to some people. "There are some people who couldn't afford to pay an accountant to prepare their tax return without a contingent provision," he says.

Zuckerman also says the contingent fee allowance will bring more competition to the profession. "[I]t's a way for new accountants to break into competition with established ones," he says, presumably producing lower prices and broader consumer choice than now exist.

Accountant Robert J. Sack, a lecturer at the University of Virginia's Darden Graduate School of Business Administration, is among those who oppose changing the rules on contingent fees. The point of the contingent fee prohibition, he says, is to prevent personal financial interest from coloring an accountant's expert judgment. For example, the FTC has agreed that in cases where an accountant is asked to attest to the fairness of an individual's financial statements for purposes of a bank loan, a contingent fee would be inappropriate. However, if the new agreement becomes final, it would allow accountants to charge contingent fees for preparing a client's tax return or for auditing a state's federal Medicare receipts.

Sack fears the use of such fees will pollute the overall character of an accountant's work. "The problem is that you have a mortal human being who wears a hat that says CPA on it. The first half of the day it's okay if he bills based on how much he saves the client; the last half of the day he has to turn the hat around and say 'Oops, now I have to be objective and ethical and [charge] no contingent fee.' "

Zuckerman says consumers, by exercising choice in the market, can root out unethical accountants as well as the profession can. "The benefit of allowing competition to decide rather than allowing agreement among competitors to decide outweighs any cost," he says.

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first of its kind in the country, would be under the aegis of the executive branch and would be headed by a non-lawyer consumer-protection expert. The agency would have the power to investigate and arbitrate a complaint. It would also have the power to provide financial restitution to an aggrieved consumer, unlike the existing state disciplinary agency. Disbarments and other professional reprimands would remain in the hands of the existing discipline system.

Wolfram, who is sympathetic to the consumer agency idea, concedes that lawyers are likely to take over such an organization, in keeping with the classic "capture theory," which states that the profession being regulated eventually captures its regulators. The reason for this phenomenon, according to social scientists, is that the people most interested in the subject being regulated — in this case lawyers — are those being regulated.

The fundamental battle of the next decade, says Wolfram, will be fought over whether legal matters must be carried out only by licensed lawyers. HALT argues they should not and points out that paralegals throughout the country now perform mundane legal services, often illegally, for clients at low cost. These services may include drawing up real-estate papers, filling out the forms for simple wills or completing the papers for uncontested divorces. "You have an entire underground industry that has sprung up because of the desperate need for more affordable services," says Ostberg. Under the current licensing system, she says, "Consumers are told they have to buy a Cadillac or nothing, and that paternalistic kind of attitude means I don't have a right to choose what I want to hire and at what price."

Last April, the Public Protection Committee of the California State Bar concurred with Ostberg that the growing number of non-lawyers providing legal services "reflects society's response to needs not met by

California lawyers." [15] In a startling about-face for the profession, the committee suggested that the California bar abandon its attempt to restrict the "unauthorized practice of law" and instead permit non-lawyers to render any legal service short of appearing in court. Under the proposal, non-lawyers would be required to register as "legal technicians" and to make it clear they are not lawyers, but would not be subject to any educational requirements. Fellmeth objects that in many of the areas in which non-lawyers are now selling services — landlord-tenant disputes, bankruptcy and immigration — there is a high risk that unwary consumers will be bilked by sharks. In a request for comment on the committee's registration proposal last December, the California bar added a number of other problems envisioned by the profession: Legal technicians would not be subject to the ethical codes that lawyers are required to observe, which prohibit such activities as misappropriating a client's funds, representing both sides of a controversy or disclosing a customer's confidences.

Commercialization: New threat or old reality?

In recent years, those who ponder professional ethics have observed with dismay a tendency toward the increasing commercialization of the professions. "What is happening is the professions are becoming indistinguishable from any other moneymaking trade," says former law Professor Michael Josephson. But, Josephson says, outside regulation is not necessarily the solution because professionals tend to view it with hostility. The key, he believes, is to retrain professionals to think of their mission as distinct in character from that of the average businessman.

Members of the professions argue that they have a greater self-interest than outsiders in preserving the good name of their professions. "One of the things people tend to forget is good lawyers are hurt by lawyers that are unethical, and they want to see those people rehabilitated so the profession is kept where it should be," says John Berry, staff counsel with the Florida bar.

But critics of the professions, like Fellmeth, argue that the professions of medicine and law are inherently different from commercial enterprises in that they have a unique capacity to wreak "irreparable harm" on their clients. The resulting message, he says, is, "Because you're in this position, we have a right to demand a bit more of you."

Josephson, though wanting professionals to adopt a professional ethic on their own, is doubtful that they can enforce it without outside help. In questionnaires that he hands out at seminars each year for a variety of professions, he discovers that each occupational group believes it is more ethical than any other group. "That's universal," he reports. "All that means to me is that when it comes to issues of propriety and ethics, we all have such heavy filters that they effectively blind us to issues that outsiders can see."

NOTES

[1] Quoted by David O. Weber in "Still in Good Standing: The Crisis in Attorney Discipline," *ABA Journal*, Nov. 1, 1987, p. 60.

[2] "Unqualified Doctors Performing Cosmetic Surgery," Subcommittee staff memo to Chairman Ron Wyden, March 27, 1989.

[3] Palso testified on April 4, 1989.

[4] Richard P. Kusserow, Elizabeth A. Handley, Mark R. Yessian, "An Overview of State Medical Discipline," *Journal of the American Medical Association*, Feb. 13, 1987, pp. 820-824.

[5] Susan Schmidt, "Doctors Rarely Lose Licenses," *The Washington Post*, Jan. 10, 1988, p. 1.

[6] Robert C. Fellmeth, *Physician Discipline in California: A Code Blue Emergency*, April 5, 1989, p. 1.

[7] AMA/Specialty Society Medical Liability Project, *A Proposed Alternative to the Civil Justice System for Resolving Medical Liability Disputes*, January 1988.

[8] Sidney M. Wolfe, "No More Juries of Peers for Medical Malpractice Cases," *The Public Citizen Health Research Group Health Letter*, April 1988, p. 6.

[9] Testimony of Joyce Palso before the House Small Business Subcommittee on Regulation, Business Opportunities and Energy, April 4, 1989.

[10] HALT, *Attorney Discipline: National Survey and Report*, 1988, p. 16.

[11] Olga M. Pina, "Systems of Ethical Regulation: An International Comparison," *Georgetown Journal of Legal Ethics*, 1988, Vol. 1, p. 603.

[12] Geoffrey C. Hazard, Jr. and Deborah L. Rhode, ed, *The Legal Profession: Responsibility and Regulation* (1988), p. 484.

[13] *Blue Ribbon Committee to Study the Functions and Operations of the Attorney Registration and Disciplinary Commission: Final Report*, April 1989.

[14] Robert C. Fellmeth, "The Discipline System of the California State Bar: An Initial Report," *California Regulatory Law Reporter*, summer 1987, pp. 1-31. Three additional progress reports have since been issued. The most recent is the *Fourth Progress Report of the State Bar Discipline Monitor*, March 1, 1989.

[15] *Report of the Public Protection Committee*, Office of Professional Standards, State Bar of California, April 22, 1988, p. 1.

Graphics: Cover, Margaret Scott; p. 293, S. Dmitri Lipczenko.

RECOMMENDED READING

BOOKS

Hazard, Geoffrey C., and Rhode, Deborah L., *The Legal Profession: Responsibility and Regulation*, Foundation Press, 1988.

Intended as a textbook for law students, this collection of excerpted essays provides fascinating snapshots of the debate over regulating the legal profession from the 19th century to the present. Observers have been bewailing the ethical downfall of the profession for some time. An excerpt from the 1933 *Encyclopaedia of the Social Sciences* states: "[F]rom an organization concerned primarily with maintaining the dignity and serviceableness of a profession, [the American bar] has become a substantial agreement among attorneys to protect each other."

Scully, Thomas, and Scully, Celia, *Playing God: The New World of Medical Choices*, Simon & Schuster, 1987.

"I believe that the medical profession should weed out its own 'bad apples.' But I also know that this can't be done without patients' help," writes physician Dr. Thomas Scully in this manual advising patients on how to deal with doctors. Scully and his wife, who co-authored the book, report that when he sat on the Nevada Medical Board in 1984, only three of 100 complaints received by the board came from doctors. The book contains an upbeat chapter advising consumers on how to get action from the discipline system when they feel they've been wronged.

Wolfram, Charles W., *Modern Legal Ethics*, West Publishing, 1986.

A complete, readable textbook on the history and current status of legal ethics by Cornell University law Professor Wolfram, one of the foremost critics of lawyer self-discipline.

ARTICLES

Alpert, Thomas M., "The Inherent Power of the Courts to Regulate the Practice of Law: An Historical Analysis," *Buffalo Law Review*, spring 1983, pp. 525-556.

Alpert's article traces the history of legal self-regulation up to the present day. "[W]hile the desire to protect the bar persists, the justifications for doing so have lost much of their persuasiveness," he writes. Arguing that lawyers can no longer portray themselves as "officers of the court," since most have little contact with the courts, Alpert supports legislative rather than court-based regulation of lawyers. "Lawyers cannot justify a claim for a special exemption from legislative jurisdiction; they should no longer be an American aristocracy," he concludes.

Kusserow, Richard P.; Handley, Elisabeth A.; and Yessian, Mark R., "An Overview of State Medical Discipline," *Journal of the American Medical Association*, Feb. 13, 1987, pp. 820-824.

This state survey by the Health and Human Services Department reports that strikingly few doctors are ever disciplined for incompetence. Problems reported in individual states, such as the rarity of complaints from health care professionals, are widespread, according to the survey. The most common grounds for disciplining physicians are the writing of inappropriate drug prescriptions, alcoholism and drug abuse by the physicians themselves.

Pina, Olga M., "Systems of Ethical Regulation: An International Comparison," *Georgetown Journal of Legal Ethics*, Vol. I, 1988, pp. 797-815.

Pina compares the American ethical code governing lawyers to those in France and Spain, and concludes that the Europeans' tighter rein might curb some of the excesses seen in the American system. For example, contingent-fee arrangements, under which the lawyer's fee is a percentage of the money he garners for his client, are common in America, but forbidden in France and Spain. Those countries' rejection of contingency arrangements, says Pina, stem from their view of the lawyer's professionalism "as consisting of a balance between the social mission of protecting the client, and the duty to society at large."

Reade, Julie M., and Ratzan, Richard M., "Yellow Professionalism: Advertising by Physicians in the Yellow Pages," *New England Journal of Medicine*, May 21, 1987, pp. 1315-1319.

The authors examine the Hartford, Conn., Yellow Pages and discover that about 12 percent of the physicians who list themselves as "specialists" are not certified by a recognized medical board, even though they have been in practice long enough to obtain such certification.

Weber, David O., " 'Still in Good Standing': The Crisis in Attorney Discipline," *ABA Journal*, Nov. 1, 1987, pp. 58-63.

This article gives a good picture of the attorney-discipline scandals that led to reform efforts in California and Illinois.

REPORTS AND STUDIES

Fellmeth, Robert C., *Physician Discipline in California: A Code Blue Emergency*, April 5, 1989.

University of San Diego law Professor Fellmeth condemns as "moribund" California's system for disciplining doctors and proposes the creation of a judicial court in place of the physician-dominated board. Available from Center for Public Interest Law, University of San Diego School of Law, Alcala Park, San Diego, Calif. 92110.

HALT, *Attorney Discipline: National Survey and Report*, 1988.

This survey by the consumer group HALT contains statistics on lawyer discipline in the states and presents HALT's critique of the existing system. Available from HALT, 1319 F St. N.W., Suite 300, Washington, D.C. 20004.

EDITORIAL RESEARCH REPORTS

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Why financial planners don't want you for a client
Will Congress put Canadian-style curbs on Medicare fees?
A bank will still give you a better deal—if you ask

IS THIS THE WORLD RECORD FOR MALPRACTICE CLAIMS?

Incredibly, an assembly-line surgeon chalked up some 200 claims in five years. But what's to stop another rogue from doing even worse?

By Mark Holoweiko SENIOR EDITOR

In the household where he grew up, plastic surgeon Richard L. Dombroff always had a sense "that we had a greater destiny than others, that the usual path for other people wasn't right for us. I think it was similar, without being pretentious, to the Kennedys'."

When he said that in 1984, at the zenith of his career, he may have felt he'd achieved that destiny. He was only 32, but already a multimillionaire.

Today, Dombroff is a convicted felon who has served jail time for turning his practice into a con game based on false advertising. He has filed for bankruptcy. He has surrendered his license to practice medicine. And, with 212 malpractice claims pending against him—at least 80 of which are already actual lawsuits—he has become probably the most sued doctor on earth.

Dombroff contends that this is a piddling amount of litigation compared with the thousands of cosmetic-surgery procedures he performed. And in fairness, he's been found liable in only one case, where the jury said he injured a young woman to the tune of $2.65 million. (On appeal, the award was reduced to $750,000.) He settled another case for $250,000. That's how the remainder are apt to be resolved: with substantial payouts by his malpractice carriers, but no admission of liability by him.

What sort of damage is he alleged to have caused? "A lot of people claim they've got excessive scarring," says Hal M. Hirsch, the attorney for Dombroff's bankruptcy trustee. Hirsch, who spent two years hammering out a procedure for settling the 212 cases in bankruptcy court, explains: "Dombroff appears to have had a tendency to take off too much skin, so that when he sewed it back together, it would pull terribly, and leave what plaintiffs' attorneys are calling 'railroad tracks.' There's a woman who had them across her stomach. She had a tummy tuck that didn't heal for over a year. It was infected. The doctors couldn't do anything because she didn't have enough skin on the rest of her body to graft.

"Some of these people feel as if they've been run through a mill," Hirsch continues, "and some of their injuries seem to reflect it. A woman who goes in to have her lower eyelids done ends up having her upper lids done instead, and so much skin is taken off that she can't close her eyes. A number of women go in to have breast surgery—reduction or augmentation—and they come out with misplaced nipples or no nipples. A girl's ears stick out like a leprechaun's, and she wants to look normal. But so much skin is taken off when they're pinned to the side of her head that her glasses won't stay up. A man gets a chin implant, and it gravitates to his shoulder."

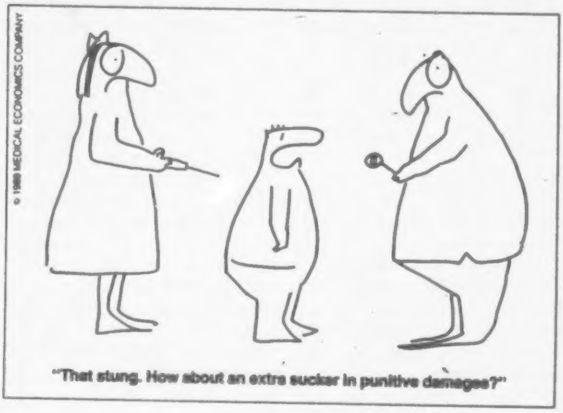
Lawyer Michael B. Wolkofsky represents about 20 of the claimants. "The most comequipment purchases that will help generate income. Buy used equipment to hold down initial costs. If you must use a line of credit to meet office expenses, start paying it off as soon as you turn a profit. If you can't cover your operating costs by the end of the first year, something's wrong. It's time to take a hard look at the financial health of your practice.

And you should hire an experienced accountant or practice management consultant to help you take that critical look—just as I should have done before I naively took the word of a hospital recruiter and believed that he could possibly have my interests at the top of his agenda.

I'm now working in a group practice in Denver. My old office space is still unoccupied. I couldn't find anyone to buy my practice in Parker, although I did manage to sell off the equipment piecemeal and transfer my 2,000 patient charts.

Slowly but surely, I'll repay my debt. I consider it a student loan from the School of Hard Knocks. I don't think I'll ever again make the mistake of cloaking myself with an attitude of invulnerability, something physicians do all too often.

The lessons I learned would apply to any new practice. If you can avoid the errors I made, you'll have a good chance for success. ■



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mon complaints involve rhinoplasties and breast implantations," he says. "Dr. Dombroff is not the normal malpractitioner, an honorable physician who makes a mistake. This guy is a perfect example of the problems the medical profession has in policing itself."

Indeed, organized medicine was aware of Dombroff almost from the beginning of this dismal affair. But the medical establishment was powerless to stop him, doctor after doctor told MEDICAL ECONOMICS.

To be sure, Dombroff had gotten off to a promising start: undergraduate education at Columbia College in New York, graduation from the Johns Hopkins University School of Medicine, internship and residency at New York Hospital-Cornell Medical Center, and an office on Park Avenue in Manhattan. But soon he veered off on a tangent.

Possibly one factor that altered his course was a moonlighting stint at a hair-replacement mill after his residency. Another was inclination: Dombroff was interested mainly in same-day cosmetic surgery, so he didn't do enough reconstructive work to get board-certified. A third was Uncle Sam's attack on the ethical restrictions on medical advertising.

As you may remember, an administrative law judge for the Federal Trade Commission declared in 1978 that the American Medical Association's ban on advertising was illegal. The FTC said the AMA rule had served to "deny consumers the opportunity to obtain the information they need to select a physician."

The Dombroffs at home in Huntington, N.Y., before their scheme unraveled.

That position became the law of the land, thanks to a Supreme Court decision in 1982. And nowhere would its flaws be more obvious, or more ironic, than in the case of Richard Dombroff. That same year, he began spending $1,000 a week to advertise.

Hyperbole fuels a booming business

Dombroff called his practice "Personal Best" (after the title of a movie). His promotional efforts were wildly successful.

By 1984, Personal Best was doing 5,000 operations annually. Dombroff leased the entire seventh floor of a building on Madison Avenue for $9,000 a month as a second office, while maintaining his original one on Park Avenue. In addition to the tony addresses, he had a doorman and provided a chauffeured limousine to take patients home after surgery, creating the impression of a first-class enterprise.

Reinforcing that image was saturation advertising aimed at making Personal Best a household name in metropolitan New York. Dombroff's ad budget would have been the envy of most hospitals, having increased nearly 30-fold in two years, to a staggering $1.5 million annually. It was far and away his biggest practice expense.

Most of this outlay bought TV spots featuring Richard's wife, Pamela, as spokeswoman. (She'd had a couple of surgical improvements herself, courtesy of Richard.) She offered listeners "a free consultation with our warm, caring, expert team." She claimed that "over 10,000 happy men and women the world over have found the Personal Best system of same-day cosmetic surgery the safe answer to big doctor bills and long hospital stays." Her tag line went: "From New York to Palm Beach to Beverly Hills, Personal Best will help you look your very best—your Personal Best. But honestly, only our address is expensive."

Dombroff and Pamela wrote the promotional hype themselves. Handouts also didn't spare the superlatives, asserting that Personal Best was "the most exciting concept in health-care delivery of this decade." A branch planned for Beverly Hills would be "the largest and most completely equipped outpatient surgery center in California." The methods used by Personal Best were "an embodiment of the team approach . . . [of] the Mayo Clinic." And the doctor (not long out of residency) "supervises a New York staff of approximately 50 professionals, and oversees approximately 30 cosmetic surgery procedures performed daily."

Of course, extravagant personal services are inconsistent with discount prices, but Dombroff flaunted the contradiction, perhaps as a way of beating his critics to the punch. He'd check into The Breakers—the exclusive Palm Beach, Fla., resort hotel—and announce that "cosmetic surgery isn't just for the jet set anymore"; anyone would be welcome at the local office he was planning to open.

Nor did Dombroff shrink from questions about his maverick approach to medicine. Referring to his advertising, he'd tell reporters, "What we've done is put the medical establishment on notice that cosmetic surgery is no longer an elitist activity." And comparing himself to John D. Rockefeller or Henry Ford, he'd brag that he'd "pioneered" the marketing of cosmetic surgery "to the masses."

> "I hope one day to control at least 50 percent of the cosmetic surgery in the country," Dombroff was quoted in one publication.

By 1985, Dombroff was touting himself as "one of the most prominent cosmetic surgeons in the world." He engaged a lawyer who specializes in such things to build Personal Best into an international franchise. In detailing his plans, Dombroff wrote: "The Personal Best Center, properly staffed, is a money-making machine fueled by advertising." His stated goal was to become the IBM or AT&T of his field. "I hope one day to control at least 50 percent of the cosmetic surgery in the country," he was quoted by one publication.

Extravagant tastes consume the profits

"All he cared about was money," says one of Richard Dombroff's former office managers. "He'd hang around until it was accounted for, then grab the cash and run. Or, if he was in the city and I was at the new Huntington office [on Long Island], I'd have to bring the cash up to his house. Every night, all the money from all the offices went to the house."

How much? "It depended on how many people paid that day," she continues. "Anywhere from $2,000 to $40,000 or $50,000 a day." In fact, by Dombroff's own testimony, he grossed between $4 million and $5 million in fiscal 1984-85. In various news media, he pegged

In their own back yard, the Dombroffs cooked up TV commercials.

it as high as $8 million.

Whatever the amount, he and Pamela had no trouble spending it. They built a $1.3 million home in a stylish section of Huntington, N.Y. It was a six-bedroom contemporary set on 5.6 acres with a pond, regulation tennis court, 20-by-40-foot pool, and electric gates.

A sample of Dombroff's 1985 expenses gives some insight into his values: He was leasing eight luxury cars (for business and pleasure) at $9,000 a month—a Rolls Royce Corniche, a Jaguar XJS, a couple of Porsches, a Cadillac limousine and a De Ville, a Lincoln Continental, and a BMW. For another $2,600 a month, he leased a 43-foot Pearson cutter-rigged yacht that slept six and was called "Personal Best." His monthly bill for car phones ran between $1,000 and $3,000. For maid service, it was $550 to $1,650. But he was putting just $72.66 toward his student loan from Johns Hopkins.

"Richard spent like a drunk," says attorney Raymond J. Damas of Lansing, Mich., who devoted much of 1985 to working on the Personal Best franchise plan. "His staff shuddered when he went out for lunch. It could be a $4,000 lunch: He might come back with a bag full of exotic smoking pipes, or a gold watch. He figured, 'All I'm spending is two surgeries.' It was a numbers game to him."

Malpractice claims invite scrutiny

One published report says Dombroff was under investigation by the New York state licensing board as early as 1983 (before he'd been in practice even two years). The health department's Bureau of Professional Medical Conduct, which handles such investigations, refuses to confirm or deny this. As reasons for their silence, various representatives cite unfamiliarity with the case, memory problems, and the confidentiality of peer review.

But by law, the bureau must investigate every serious complaint against a physician. As of 1983, Dombroff had been hit with more than half a dozen malpractice suits. One plaintiff said Dombroff put her cheek implants in crookedly, then mismanaged a postoperative infection so badly that she had to be hospitalized for 10 days. A breast-augmentation patient, who also suffered a post-op infection, claimed that she underwent corrective surgery twice, but wound up with scarred breasts of different sizes. In the case that was ultimately settled for $250,000, a woman who'd wanted Dombroff to remove a bulge from one thigh was left with grotesque scars across the bottoms of both buttocks.

Evidently, some plaintiffs took their gripes to the licensing authorities, and an investigation was launched.

Before long, physicians began squawking, too. Vickie Silver, a New York lawyer who represents one of the early plaintiffs, says: "I've spoken to dozens of plastic surgeons locally who've heard of Dombroff, seen some of his surgeries, and were outraged by the results. A few told me that they'd reported him to the licensing board. They didn't like the way he ran his business like some sort of fast-food takeout."

Ditto, says Alan H. Gold, who was president of the New York Regional Society of Plastic and Reconstructive Surgery

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from 1984 to 1985: "There were multiple complaints about him to the state medical board. He was being investigated for years, but nothing was done."

According to another knowledgeable source, Dombroff hampered—but didn't stop—the board's investigation by contesting its subpoena for some of his patient records.

Meanwhile, no one was trying to halt Dombroff's advertising. Back before the FTC stepped in, medical societies slapped doctors down if the type in their Yellow Pages listings was a tad too bold. But since then—afraid that a censured doctor might retaliate with an antitrust suit—organized medicine has been treading softly, no matter how flamboyant the ads.

Dombroff was a member of both the Medical Society of the State of New York and the New York County Medical Society. Neither would discuss the steps it took to rein him in. But digging by MEDICAL ECONOMICS revealed what had been done.

In October 1984, the state society recommended that the malpractice carrier it had helped form—Medical Liability Mutual Insurance Co.—drop Dombroff as a policyholder because he had nine suits against him. The following May, MLMIC refused to renew his coverage. "There's a conspiracy by the New York state and county medical societies to drive me out of business," Dombroff protested. Scarcely skipping a beat, he then got a new policy from the Medical Malpractice Insurance Association, New York's joint underwriting association, which cannot refuse to insure a physician.

Equally ineffectual was the hospital where Dombroff sent most of his inpatients—New York Eye and Ear Infirmary—which didn't restrict his privileges. However, it's not clear whether the institution had any reason to do so, since he did the vast majority of his surgery in the office. For that reason, it would hardly have mattered even if he'd been kicked off the staff.

Since Dombroff wasn't board-certified, he couldn't join the

Set 'em up!

An 8-year-old boy who accompanied his mother to my office watched my nurse mixing a blood sample with solution for a wbc. "Oh," he asked, "what are you making—a Bloody Mary?"

—*G.M. Buehler*, M.D.

American Society of Plastic and Reconstructive Surgeons, so that group couldn't have disciplined him if it had wanted to. However, some members of the regional ASPRS chapter assisted the licensing board investigation; others, like Alan Gold, debated him in the news media.

"The difficulty with a practice like his, built on advertising, is that it bypasses the checks and balances of the referral system," says Gold. "Patients don't choose the surgeon on the advice of their primary-care physician, or that of a friend or family member. They simply answer an ad.

"And physicians who advertise a lot tend to be very liberal about whom they'll operate on. Somebody's got to pay for that huge advertising bill, so they stretch the indications for surgery until they've created a mill.

"While realizing that this was the nature of Dombroff's practice, there was nothing we could do except try to educate the public. We don't have the power to police our own ranks, and the state board is slow because it wants to assure everyone of due process."

The media take the scandal public

In November 1984, the public got its first real glimpse inside Personal Best. A feature story

Close your eyes. Now have someone read this to you.

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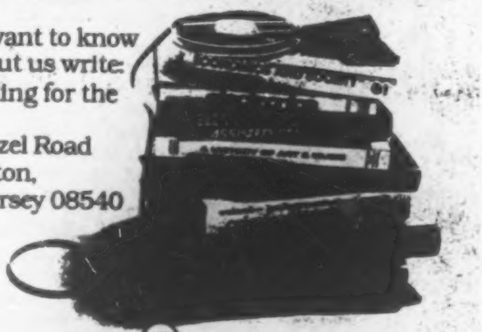

Recording for the Blind, Inc.
LEARNING THROUGH LISTENING

by free-lance writer Daniel Kagan in Manhattan, Inc. magazine used Richard Dombroff's own words to depict him as far more concerned about making money than about patients.

A few months later, Kagan began researching a follow-up article for Newsday, the main newspaper on Long Island. Alleging that Kagan had made defamatory remarks during interviews, Dombroff sued the writer for $11 million.

Kagan says the suit was intended to frighten Newsday into dropping the project. But Newsday stuck to its guns and provided Kagan with an attorney. Dombroff abandoned the claim in August 1985.

That month, the CBS News show "West 57th" revealed more of what went on behind the Personal Best facade. On camera, Dombroff claimed to be able to perform a rhinoplasty in 20 to 25 minutes, a face-lift in 45, upper and lower blepharoplasties in 40, and a breast augmentation in an hour.

Cut to a flabbergasted mainstream plastic surgeon sputtering, "I've never seen anybody do that—that kind of speed."

Cut to a woman identified as "Cathy" recounting how she went to Personal Best because "I was an A-cup and wanted to be a C-cup." Instead, she got seven operations interspersed with pain, infection, and episodes in which "there was gobs and gobs of blood and pus and mucus and all sorts of things coming out."

On TV, Dombroff claimed he could perform a rhinoplasty in 20 to 25 minutes, a face-lift in 45 minutes, and a breast augmentation in an hour.

Newsday's exposé appeared in November 1985, shedding more light. It turned out that the "free consultations" at Personal Best didn't involve doctors. Potential patients merely got appointments with pretty young saleswomen (Dombroff called them "consultants") who earned a $10 commission on every procedure they booked. It wasn't unusual for such a "consultant" to thereby boost her weekly income by $500.

The Newsday article documented that unlicensed foreign doctors were administering anesthesia at Personal Best, as well as completing operations after Dombroff made the initial incisions. Sterile technique was often breached because, in effect, the boss considered it a waste of time and money to scrub and don a clean gown and mask between procedures.

As the media scrutiny intensified, the malpractice suits mounted. Approximately 30 cases were pending against Dombroff by the end of 1985. Within a few months, the number of lawsuits would nearly triple. But the full scope of his scheme had yet to come out.

The doctor tries to cover himself

No one else may have realized it, but Dombroff clearly knew by 1985 that he was washed up. In August, when the "West 57th" segment was broadcast, he transferred to Pamela his half-interest in their home, his Personal Best stock, and the trademark rights. (The bankruptcy court took the house from Pamela and allowed it to be sold for the benefit of creditors.)

The same month, he closed one of the New York offices, and had outgoing workers sign statements "that during my em-

ployment at Personal Best, I was never aware directly or indirectly of any improprieties committed by Dr. Dombroff. . . . I always witnessed Dr. Dombroff fully inform each and every patient prior to surgery of the possible benefits and risks of each procedure. . . . I never witnessed nor was made aware of a situation or incident in which any non-licensed individual performed surgery, placed sutures, administered anesthesia. . . ."

In August, too, he purchased a business-protector insurance policy from Provident Life and Casualty Insurance Co.—purportedly through an agent friend of his. If he became disabled, Provident would pay him a monthly income of $50,000 to a maximum of $1.2 million. Three months later, Provident determined that temporal lobe epilepsy had rendered Dombroff totally incapable of performing surgery. The company now says it investigated further and after about six months stopped paying him.

Finally, Dombroff indulged in a bit of "good citizenship" that would eventually cause his downfall. He squealed to the Suffolk County district attorney on two terminated "consultants" for allegedly defrauding Personal Best's health insurance carrier. Specifically, he said Terry Hessel had falsely claimed to have undergone an operation at Personal Best in January 1985. The procedure had taken place a year earlier, before she was hired. And Margaret Wagner, Dombroff said, had forged his signature on a letter directing the insurance company to send Hessel the $2,850 reimbursement, which is what it did.

As his empire falls, the doctor is indicted

In January 1986, Pamela Dombroff served her husband with a complaint for divorce. It seems that Richard had moved in with one of his "consultants."

Because of supposed financial difficulties resulting from all the adverse publicity, his Rolls and Jaguar were repossessed, and he forfeited a $30,000 security deposit on one of his offices.

In February, Terry Hessel was told by a detective from the Suffolk County district attorney's office to surrender for booking on a charge of insurance fraud stemming from Dombroff's complaint. But her attorney persuaded prosecutors that "she had learned how to commit her insurance fraud from Dr. Dombroff's own continuing course of similar activity." In exchange for immunity from prosecution, Hessel agreed to testify against her old boss.

She informed police that patients usually paid in full before surgery, but afterward a phony claim with an inflated fee was often submitted to an insurance company at Dombroff's direction. Margaret Wagner backed up her story.

Armed with a search warrant, police raided the Huntington office and carted away nine boxes of medical and business records. Then the district attorney's office mailed questionnaires to 1,500 Personal Best patients, asking when they'd been treated, by whom, and how the bill was paid.

"We were inundated with hysterical phone calls," says Linda Spahr, the case prosecutor. "Hundreds of people were enraged at Dombroff. Some said they wanted to kill him. Others wrote us long letters about their experiences with him. But it wasn't until later, after listening to 50 or 75 grand jury witnesses, that I realized what the case was all about."

While she was putting the pieces together, more of Dombroff's cars were repossessed, and he was evicted from the Huntington office. The furnishings were set out on the sidewalk, where passersby helped themselves.

In April 1986, Irma and Jose Baez won a $2.65 million malpractice verdict—the only one against Dombroff so far. Mrs. Baez, a young mother of five, had gone to him in 1982 for a breast-reduction operation. She'd come away mangled, her breasts heavily scarred and misshapen. During trial, Dombroff conceded liability. In the end, the judge cut the award to $1.5 million, which still exceeded Dombroff's $1-million-per-incident coverage. The amount was cut to $750,000 on appeal.

Three days after the Baez verdict, he and Personal Best filed for a Chapter 11 bankruptcy (the kind where the business reorganizes and keeps going to pay off debts). Dombroff blamed his money woes on "inaccurate" negative publicity about his practice, and big debts incurred while trying to expand. "When all the facts are made known," he predicted, he would "be vindicated."

His bankruptcy papers showed assets of less than $50,000, and liabilities of more than $5 million. The mountain of debt included the original Baez

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"I'm in word processing. What do you do?"

Symbols of high quality concealed the darker truth within.

award, but few of the 65 other malpractice claims he listed (since the damages hadn't been determined.)

Actually, more than 80 such suits were pending. His bankruptcy filing automatically halted action in all of them, and prevented any other patients from suing. (But they could still file claims against him with the bankruptcy court, and with his insurers.) Thus, the guy who'd aspired to be the IBM of cosmetic surgery had become its Johns-Manville instead.

Over in matrimonial court, a judge ordered him to pay Pamela support of $300 a week for their two children (who are now 11 and 9). Until brought into court on contempt charges, Dombroff ignored the order.

In June 1986, a Suffolk County grand jury indicted Richard and Pamela Dombroff. It charged them with a scheme to fraudulently separate patients from their money by promising high-quality surgery that the Dombroffs had no intention of delivering. Advertising created a false perception of Personal Best "as a nationally known, long-established, and professionally respected clinic."

The indictment went on to say that actually, patients didn't even get preoperative physicals, blood or urine tests, or a chance to speak with the doctor; often they underwent ghost surgery; "wholly untrained employees," such as the chauffeur, placed and removed sutures and prescribed drugs; and surgery was so overbooked that Dombroff sometimes had three patients undergoing surgery at once.

A former "consultant" adds: "We'd tell patients, 'Yes, you'll get exactly what you want.' We knew it was a lie. Dombroff would go in to do a nose, and the patient would say, 'I want the bump taken away.' But he'd just cut her and move the nose around a bit, that's all. She would come back because the bump was still there. 'Oh, it's because of the swelling,' he'd say. He didn't even try to fix things properly."

Why didn't more people go to the authorities? "Dombroff collected from them up front," she says. "Many couldn't afford the surgery, so he'd say, 'If you have insurance, I'll put it down so that insurance will pay for it'—so it appeared to be plastic reconstructive surgery, not elective cosmetic. It was fraud." And as accomplices, those patients weren't going to raise a stink, whether or not they got their money back.

The Dombroffs were also charged with aiding and abetting unlicensed practitioners, and with numerous counts of filing false insurance claims. Four others were indicted for the unauthorized practice of medicine: Linda Choi, Padinjarathara Madan Mohan, and Norberto M. Jurado, all foreign-trained but unlicensed doctors; and Joseph Salaska, a chauffeur/bookkeeper.

The doctor pleads guilty to fraud

As police escorted him and Pamela, handcuffed, to the county lockup, Dombroff told reporters: "We're fortunate to live in a democratic society. Justice will prevail." All the suspects pleaded not guilty. Bail was set at $50,000 for the doctor, $2,500 for his wife, and $1,000 apiece for the others.

Through his lawyer, Dombroff contended that virtually every aspect of the case against him was flawed—from the testimony of former employees and patients, to the conduct of the police and prosecutor. According to his 168-page motion to dismiss the charges, he was the real victim.

But the fancy footwork wouldn't enable him to waltz away scot-free. The three foreign doctors were facing up to four years in jail if convicted. In exchange for the district attorney's recommendation that they spend no time behind bars, they switched their pleas to guilty and agreed to help nail Dombroff.

Ultimately, in February 1987, Richard Dombroff pleaded guilty as charged to the felonies of scheming to defraud in the first degree, and aiding and abetting the unlicensed practice of medicine. Maximum punishment would have been eight years in prison. But because of a plea bargain, he was sentenced to three months in county jail, 1,350 hours of community service, and five years of probation—and was required to surrender his license to practice medicine in New York.

He also pleaded guilty to some professional-misconduct charges brought by the licensing board, which had assisted prosecutor Linda Spahr. These were such things as gross failure to manage infection in breast-enlargement cases, or to fracture the nasal bone when indicated during nose jobs.

At his sentencing in April 1987, Spahr characterized him as "motivated by greed, lust, and self-interest." According to the grand jury testimony of a Personal Best employee, she noted, Dombroff had once boasted, "I could sell cancer."

She said there was also testimony that "a patient was screaming from pain while being operated on, and he said, 'Stick a sock in her mouth so the other patients don't hear.'"

Another woman underwent breast surgery at Personal Best several weeks after giving birth, while she was still lactating. "She ended up with emergency surgery by another doctor since this doctor [Dombroff] wouldn't respond to her cries for help," Spahr said.

In yet another case, she continued, a woman "had collagen injections in her eye by a young clerk who had absolutely no medical training, who was acting on Dr. Dombroff's direction, and that woman has permanent damage to her eye now. . . . I

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think the evidence showed in the grand jury that this defendant did any kind of surgery on anybody, as long as they paid him money." For instance, she said, Dombroff would operate on diabetics without any special preparations, and, contrary to the usual practice, he'd do dermabrasion on dark-skinned people, and liposuction on anyone who could afford it.

"We believe firmly that this man should never touch a patient again," Spahr concluded. "The only way to guarantee that is [to let him cop a plea] because, unfortunately, the licensing system in this state at times has no teeth." Also, she wanted to spare patients the embarrassment of testifying about extremely personal matters at a highly publicized trial.

Pamela Dombroff pleaded guilty to the misdemeanor of scheming to defraud in the second degree, and was released without punishment. "She was kind of taken in by him as well," says Spahr. "She was kind of pathetic." The chauffeur confessed to the unauthorized practice of medicine. Like the unlicensed doctors, he was simply warned never to commit the crime again.

Bankruptcy sets off a feeding frenzy

The upshot? Dombroff's bankruptcy was converted to Chapter 7, in which the business goes belly-up and the assets are divided among creditors. Although he didn't list it as such, the doctor had a tremendous asset in the form of malpractice coverage totaling $24 million. Plaintiffs' lawyers homed in: Today more than 100 attorneys of record are involved in the bankruptcy case, most of them representing malpractice claimants.

> The chauffeur confessed to the unauthorized practice of medicine. He was simply warned never to commit the crime again.

While that's a lot of money, it apparently isn't enough to compensate for all of the patient injuries. As U.S. Bankruptcy Judge Cornelius Blackshear put it at a hearing on the subject, "I think we all agree that the insurance coverage will not be sufficient to pay everybody 100-cent dollars."

"Coverage is at the bottom of it because the name of the game is money," responded one plaintiff's attorney candidly. If there wasn't enough, "What's the point of getting involved in all sorts of convoluted and wasteful legal arguments? That's the time to sit down and start to whack up the pie."

And so they are, in what may be the most unusual malpractice settlements ever. The claimants will be segregated according to which of eight Dombroff insurance policies their injury falls under. (The maximum coverage under each policy is $3 million.) Each claimant will answer a set of interrogatories, be examined by a court-appointed plastic surgeon, and be photographed by a court-appointed photographer. Then they'll try to reach settlements with the insurers. When that doesn't work, a minihearing will be held solely on the issue of damages, which the bankruptcy judge will determine. Dombroff won't admit any liability.

Whatever the amount eventually paid to these plaintiffs, it's coming from the pockets of all the New York doctors who pay premiums to

Dombroff's insurers. Whether there's any justice in that depends on whom you blame for the failure to clamp down on him quickly.

P.S. "In New York, a doctor can't permanently surrender his license," says attorney Diane Abeloff of the Office of Professional Medical Conduct. "One year from the date of surrender, he's entitled to apply for restoration of his license. Even if a criminal court said he must surrender his license forever, that 'forever' is only in effect for a year."

Apparently, then, the only thing that would prevent Dombroff from trying to return to medicine now—should he want to—is his five-year probation. He'd violate that if he applied before April 1992. ■

[illegible]

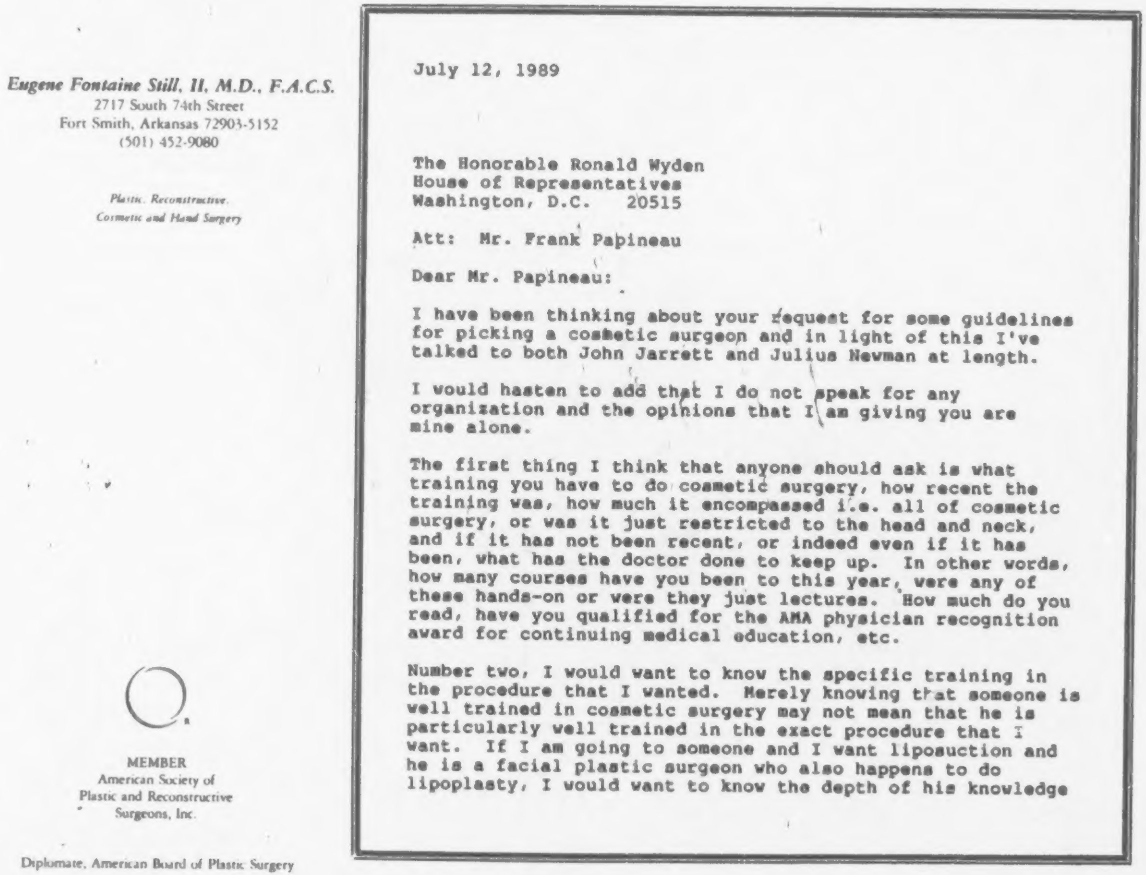
Cosmetic surgeon [illegible] grant our request for an interview [illegible] sent him a draft of the [illegible] he responded by phone, [illegible] manuscript as totally inaccurate, un[illegible] sensationalistic, and mean-spirited [illegible]

"Look, 10,000 or 15,000 procedures were [illegible] performed by me and my associates over the [illegible] course of four or five years [illegible] even assuming that each of the [illegible] against me is valid [illegible] ord: . . . no better or worse [illegible] than any other plastic surgeon [illegible]

He suggested, "Maybe [illegible] tor here that we haven't explored [illegible] part of competitors who [illegible] competitive environment who don't want to [illegible] see prices brought down 50 percent or more [illegible] greed on the part of litigants, many of whom [illegible] were perfectly happy with their surgical results; and greed on the part of lawyers [illegible]

"In two or three years, we built a larger cosmetic-surgery practice than guys who'd been [illegible] out there 20 or 30 years. They were [illegible] of how quickly this had grown, how successful [illegible] this had been."

Yet he expressed mixed feelings about the [illegible] advertising that made it possible [illegible] advertising is a bad thing, although [illegible] threat to the established [illegible] that irritates the powers that be." On the other [illegible]



Eugene Fontaine Still, II, M.D., F.A.C.S.
2717 South 74th Street
Fort Smith, Arkansas 72903-5152
(501) 452-9080

Plastic, Reconstructive,
Cosmetic and Hand Surgery

MEMBER
American Society of
Plastic and Reconstructive
Surgeons, Inc.

Diplomate, American Board of Plastic Surgery

July 12, 1989

The Honorable Ronald Wyden
House of Representatives
Washington, D.C. 20515

Att: Mr. Frank Papineau

Dear Mr. Papineau:

I have been thinking about your request for some guidelines for picking a cosmetic surgeon and in light of this I've talked to both John Jarrett and Julius Newman at length.

I would hasten to add that I do not speak for any organization and the opinions that I am giving you are mine alone.

The first thing I think that anyone should ask is what training you have to do cosmetic surgery, how recent the training was, how much it encompassed i.e. all of cosmetic surgery, or was it just restricted to the head and neck, and if it has not been recent, or indeed even if it has been, what has the doctor done to keep up. In other words, how many courses have you been to this year, were any of these hands-on or were they just lectures. How much do you read, have you qualified for the AMA physician recognition award for continuing medical education, etc.

Number two, I would want to know the specific training in the procedure that I wanted. Merely knowing that someone is well trained in cosmetic surgery may not mean that he is particularly well trained in the exact procedure that I want. If I am going to someone and I want liposuction and he is a facial plastic surgeon who also happens to do lipoplasty, I would want to know the depth of his knowledge concerning my operation so that I can make the decision as to whether or not he might be an appropriate choice.

Number three, I would ask for the number of the procedures similar to mine that this doctor had done and again how recently they had been done. Someone who used to do a lot of facelifts but lately has been doing only hand surgery may not be an appropriate choice.

Number four, the Boards, organizations that they are members of. Here I will go into a little bit more detail because I think there are going to two groups of organizations and Boards that are going to be fairly distinct from one another. The first is going to be the well recognized, i.e. American Board of Plastic Surgery, American Board of Otolaryngology, the American Board of Dermatology. All of these are Boards recognized by the American Board of Medical Specialties and certainly have a great deal of merit to those who have passed their examination. In addition there will be a lot of the older societies, the American Society of Plastic and Reconstructive Surgeons, Academies of Dermatology, Otolaryngology, etc.

New on the block, arw going to be the American Board of Cosmetic Surgery, the American Academy of Cosmetic Surgery, the Academy of Facial Plastic and Reconstructive Surgery. These have really not been around long enough to be legitimate by longevity. They do, though, have to me a tremendous place here. The American Board of Cosmetic Surgery has been established in an effort to assure a degree of excellence in those who have taken the exam and at the very least would show an extreme interest which would in most cases carry over to a fairly well prepared surgeon. From what I've been able to understand, the American Board of Medical Specialties is a rather closed organization and getting recognition by this group is going to be extremely difficult for the American Board of Cosmetic Surgery. I do believe, however, that given time it will persevere and will become a mark of excellence. I personally have no problem in telling people about the Board of Cosmetic Surgery and explaining to them that while this is not accepted yet by the medical community at large, it is a group of people such as myself who have gotten together to try to assure excellence to the consumer and that this shows not only that some of my peers recognize my qualification but also exhibits to them a continuing effort on my behalf to stay current and to learn the new procedures that are coming about and this has been quite well received by my patients. The organizations which may or may not purport to establish excellence in their membership still show a willingness by most of the members to engage in continuing medical education and I think this is laudable. I would, however, have everyone point out that membership in these organizations does not have nearly the requirements and that any assumption of excellence because of membership would be false.

I agree totally and I think that you will find immense support in the medical profession as a whole with the idea that one should not do procedures in the office that they do not have privileges to do in a regular hospital that is accredited by the Joint Commission. I think that you will find that if this goes into effect there will be a veritable flood of applications by non-qualified people for hospital privileges that they shouldn't have and there will be some problem in trying to ethically keep those people away who should be kept away, let those in who should be let in, and protect those who are trying to guard the door legitimately from being sued at every turn. The possibility of having this application for cosmetic privileges tied up in court really boggles my mind.

I also agree with the idea of an office accreditation. I think that the Joint Commission, the Triple-A and Quadruple-A all probably do a good job. There is, however, some opportunity for exploitation in having an organization that is under control of the organization as a whole examining the membership. This could possibly be addressed by having spot checks by competing inspection organizations and/or having the facilities examined on a rotational basis by all three.

I think that it would be incumbent upon every operating

Page 4

physician to describe to the patient the major risk of surgery and the major risk specific to the procedure which they are requesting. It is extremely difficult to know what is and what isn't an informed consent, how much should be told, what the risk should be that are conveyed versus those that are so slight or rare that they are not brought to attention.

The American Society is now working on what would be considered informed consent by the vast majority of doctors and we are making some progress in getting those formalized. I think it would be also very useful for the doctor to disclose his personal record of complication occurring with these procedures. Certainly if they are less than the national average he will be proud, and if they are more than the average nationally, the patient should be aware.

I hope that some of these ideas will help. Again, I very much appreciate the opportunity that you have given me to be heard in this matter and I look forward to continued association and of being of assistance in the future.

Sincerely,

E.F. Still, II, M.D.

EFS/gf

Theodore A. Tromovitch, M.D.
Samuel J. Stegman, M.D.
Richard G. Glogau, M.D.

Dermatology
Dermatologic Surgery
Mohs Micrographic Surgery
Cosmetic Surgery

April 19, 1989

The Honorable Ron Wyden
House of Representatives
1406 Longworth House Office Building
Washington, D.C. 20515

Dear Congressman Wyden:

By now the hearings you convened on cosmetic surgery should be finished. Hopefully you have a broader view and appreciate the self-interest of the general plastic surgeons in getting you to hold such hearings.

Did you learn that there has never, ever been a single serious side effect of dermatologists doing liposuction under local anesthesia? Dermatologists seek out the safest method of doing a procedure.

Did the general plastic surgeons testify about the plastic surgeon who killed his partner in the Midwest doing liposuction? Did someone testify about the three people who died receiving cosmetic surgery by a general plastic surgeon in Hawaii?

To deny groups of physicians the right to do cosmetic procedures denies the public the opportunity for safer and better procedures being developed.

Was there testimony by the Federal Trade Commission who obtained an injunction against the general plastic surgeons to prevent a monopoly situation?

An impartial reading of the evidence should get you to appreciate the power/greed play which you unfortunately have become a part of, and should allow you to clearly see that if anyone needs your help it is those specialties trying to improve the delivery of cosmetic surgery at a lower cost and in a safer manner. We need your help against the monopolistic desires of a small segment of general plastic surgeons. I hope you will extend this help to making all facilities which in any way have a federal benefit open to all specialists who are willing to learn the new procedures, be proctored in the situation, and be guided by fair and equitable ongoing peer review.

Sincerely,

Theodore A. Tromovitch, M.D.
TAT/cmf

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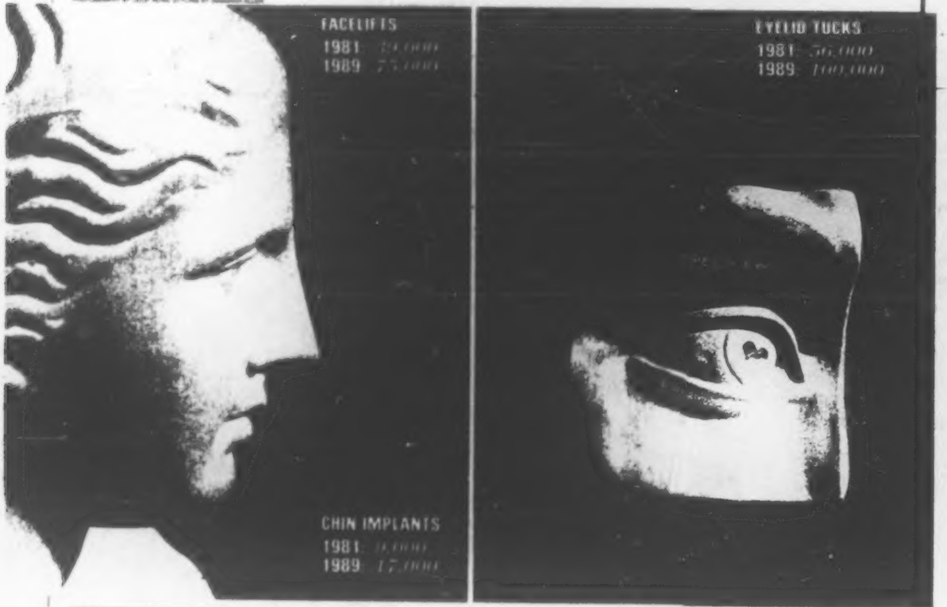
NEWS YOU CAN USE

BUYING THE PERFECT BODY

New and better techniques have made cosmetic plastic surgery more popular, more convenient and generally safer. But not necessarily risk-free. Or wiser


FACELIFTS
1981:
1989: 75,000
CHIN IMPLANTS
1981:
1989: 17,000
EYELID TUCKS
1981: 56,000
1989: 100,000

With Susan, it was her knees. "They drove me crazy," says the 28-year-old waitress and aspiring actress in Los Angeles. "There was too much fat around them. My nose had a bump I didn't like. . . . And my breasts just didn't fit with the rest of me." So last February, in a single procedure, a surgeon suctioned away the fat around Susan's knees, excised the bump on her nose and implanted a fist-size bag of silicone gel in both breasts. Exults Susan: "This is what I should have been born looking like."

John Hunter, 54, originally sought plastic surgery to remove a birthmark and scar from his forehead but elected to have a facelift, eyelid surgery and a chin implant at the same time. "It wasn't that I thought I was ugly or that I lacked self-confidence," says the chairman of a Florida-based computer-design firm. "I just wanted to feel better about the way I looked, and it worked."

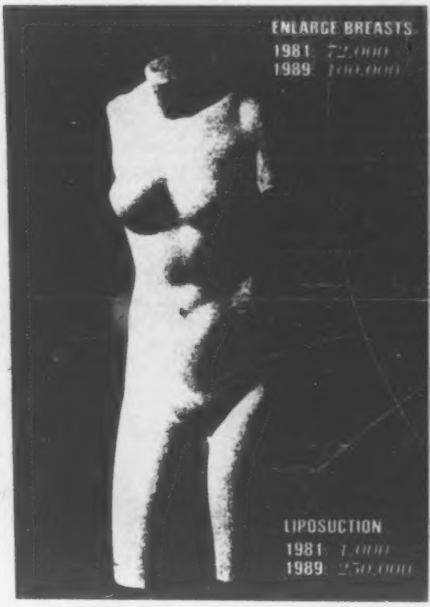
Once ridiculed as neurotically narcissistic and never a topic for public revelation, cosmetic plastic surgery has become positively trendy. Celebrities who proudly display new faces, noses, lips and breasts seem to have persuaded hundreds of thousands of other Americans that getting their noses bobbed and chins cleft, tummies tucked and upper legs suctioned of fat is no more worthy of serious concern than having a tooth filled. An estimated 750,000 people had cosmetic surgery in 1988, compared with 300,000 in 1981, and that only counts procedures performed by certified plastic surgeons. The total number of operations is likely around 1.5 million, since an increasing number of doctors uncertified in plastic surgery are also now doing cosmetic procedures. An estimated half-million others underwent hair transplants or had collagen injected beneath their skin to smooth wrinkles or plump out lips.

Nurtured on instant gratification, baby-boomers are once again at this latest cutting edge. "I have 35-year-old women coming in for facelifts," says Dr. Robert Goldwyn, a Boston plastic surgeon. And Dr. Susan Chobanian, a Beverly Hills plastic surgeon, reports: "Women who have perfectly nice full-sized breasts ask me if I can make them even larger. It's crazy. I tell many of them no, but I know they can get it done somewhere else." With the stigma reduced, more men, too, are lining up. A quarter of all nose jobs, 10 percent of facelifts and 18 percent of eye procedures are now done on men.

Why diet?

Liposuction, a relatively new technique, is what has drawn in most of the young. Developed in France and imported to the U.S. in the early 1980s, liposuction, which removes fat, is now the most common cosmetic procedure. Too often, critics say, it's used as a substitute for dieting and exercise (see box, page 68).

Advances in cosmetic and reconstructive plastic surgery in the last decade have made the most common procedures safer, better and more convenient, if not cheaper. Facelifts, for example, used to



RESHAPE NOSE
1981: 51,500
1989: 95,000

merely tighten the skin of the face, with results rarely lasting beyond two or three years. Doctors now perform a much more elaborate procedure, removing fat and shifting muscles as well as tightening the skin. The result now lasts five to seven years. New techniques allow surgical repair of birth deformities and accident-related injuries that was not possible 10 or 15 years ago. Advances in microsurgery and bone resculpting make reattached limbs look more natural. Improved skin-graft techniques save thousands every year from hideous burn scars. Breast reconstruction following a mastectomy eases some of the psychological scarring. And newer methods are being developed, such as bone grafts to build up misshapen features and computers that can redesign a patient's face before doctors make the first incision. In-office computer videos allow surgeons to show patients alternatives and what to expect. A nose, for example, can be displayed in various shapes and sizes.

Better results, troubling ethics

The advances have meant techniques that used to yield fairly high rates of poor results have been supplanted by methods that produce good to excellent cosmetic results for 85 to 95 percent of patients (see table, page 70). In addition, the 1 to 5 percent rate of serious complications for common cosmetic procedures is no greater than for most other forms of major surgery.

But the land of nip and tuck faces troubling ethical questions as the popularity of cosmetic surgery soars. Are too many people with minor physical flaws, or perhaps no obvious flaws at all, choosing plastic surgery? Is the preoccupation with physical appearance in our culture healthy? "I don't think so," says Harvard's Goldwyn, author of *Beyond Appearance: Reflections of a Plastic Surgeon* (Dodd, Mead & Company, 1986, $16.95). "It troubles me. There are more people getting cosmetic surgery today than perhaps should be."

Many surgeons clearly are not discriminating carefully between good and bad candidates for surgery. The sheer glut of doctors practicing plastic surgery is one reason. A growing number of new physicians are choosing cosmetic surgery because it's such a lucrative specialty and because patients pay cash, usually up front; most procedures are not covered by health insurance.

THE SIMPLISTIC LURE OF LIPOSUCTION

UNLOADING THOSE SADDLEBAGS FOR GOOD

Plastic surgeons call it "diet-and-exercise-resistant fat." But most people know those unshrinkable blobs of blubber as love handles, saddlebags and spare tires. These unwelcome extras have become the targets of liposuction, a surgical technique that literally sucks fat out from under the skin with a pencil-thin, foot-long metal probe attached to a pump. Since liposuction was introduced in the U.S. in 1981, it has become the hottest form of cosmetic surgery. An estimated 150,000 people had liposuction last year, and the number is expected to climb to 250,000 in 1989.

Although the procedure is generally considered safe and effective, its raging popularity belies the fact that it cannot produce miracles and can be deadly if done improperly. At least 11 liposuction patients have died from such complications as infection, fluid loss and blood clots. Countless others have ended up with rippled "washboard" skin and other undesirable results at the hands of poorly trained practitioners. "Three or four weeks after surgery, my right leg sort of caved in, my knee swelled up and I could not bend my leg," Angela Brown of Bowie, Md., told a recent congressional hearing on the hazards of plastic surgery. Her doctor had taken out too much fat when trimming down her thighs, leaving a sunken pocket of flesh that clung to the muscle, a condition that can be very difficult to correct. Another plastic surgeon advised Brown, 42, to undergo fat transplantation, a still experimental procedure, to fill in the depression. Fat from her abdomen, left leg and arms was transferred to her right leg. But even that was only partially successful, leaving Brown with a noticeable indentation. She now warns prospective patients that "liposuction is surgery and things can go wrong."

Warning sounded. The craze for a quick fat fix among women, who make up about 90 percent of liposuction patients, shows no signs of abating. And the immensely lucrative procedure has lured so many doctors to take up the craft that virtually anyone who wants liposuction can get it. A committee of the American Society of Plastic and Reconstructive Surgeons (ASPRS), the leading group of its kind,

Crystal ball. *By using a special computer, Dr. Oscar Ramirez gives Lorraine Smith, 43, a sneak preview of her future face. The image on the left is Smith's preoperative profile; the one on the right is her profile after a facelift and nose job. Smith knew just what to expect when her bandages came off last week.*

Perhaps more important, it has lured practitioners away from other specialties. The House subcommittee on Regulation, Business Opportunities and Energy held hearings on cosmetic surgery last month and concluded after a six-month probe that it was too easy for doctors whose primary training lay in other medical fields to set up a practice in plastic surgery. Liposuction was the most common procedure done by those untrained in plastic surgery. In one case, a woman died and one was severely injured after undergoing liposuction by a Texas gynecologist untrained in the technique. But other procedures, too, according to the findings, were being done by doctors who had switched, most often from emergency medicine, general surgery or ear, nose and throat medicine. The committee recommended that state medical boards step up efforts to regulate who should be allowed to perform plastic surgery. "Too many hucksters are out there just to make a fast buck," says Representative Ron Wyden (D-Oreg.), chairman of the subcommittee.

Meanwhile, more doctors doing cosmetic surgery means stiffer competition for patients. This translates into less willingness on the part of many plastic surgeons to say no to patients who may have little need for cosmetic surgery or who may be poor candidates psychologically (see box, page 75).

Many plastic surgeons, in fact, have mounted aggressive advertising campaigns to recruit patients. Perhaps the most notorious ad to date, appearing in *LA Magazine*, is an eight-page foldout that highlights a buxom woman in a bathing suit standing next to a sleek sports car and, in large type, the words: "Automobile by Ferrari. Body by Forshan." The reference is to Dr. Vincent Forshan, a plastic surgeon in Rancho Mirage, Calif. The ad extols not only Forshan's surgical skill but his "beautifully appointed examination rooms . . . with Joan Miró prints and color-coordinated reclining power tables."

The hype factor

It turned out that Forshan had never worked on the model in the ad and did not know that another plastic surgeon—Dr. Charles Smithdeal of Los Angeles—had. Smithdeal was not happy about what he called false advertising. Forshan argued that the ads didn't say *that* woman's body and now says, "We never meant to mislead anyone." In a later issue of *LA Magazine*, Smithdeal appears to have had the last word, or ad, with the same model posing next to another red Ferrari, along with the message: "Body by Smithdeal."

Dr. Norman Hugo, immediate past president of the American Society of Plastic and Reconstructive Surgeons (ASPRS), is exasperated by the squabbling and by the hype that occasioned it. "This ad and so many others like it are aimed at undecided people. That's O.K. when you're selling cars or appliances but not to sell surgery," he says. Plastic surgeons who advertise disagree. "I don't think anybody makes a decision to have surgery on the basis of an ad," says Dr. John Williams of Aesthetica, a Center for Aesthetic Plastic Surgery in Los Angeles. "It brings a few patients in the door. After that, the same careful consultation occurs." The California attorney general's said in a 1987 report that the technique was being overused largely because "inadequately trained surgeons" were operating on poor candidates for the procedure. The report singled out extremely obese individuals, who do not benefit from the relatively few pounds that can be removed by liposuction, and people whose weight problems could be solved other ways. A woman who is 10 to 15 pounds overweight and has not sincerely dieted or exercised should not be slated for liposuction, doctors say, but many people are having the procedure anyway.

The ASPRS, of course, advises having liposuction done only by a board-certified plastic surgeon. But other medical specialists, such as dermatologists, argue that they produce equally good results, and there is no evidence to the contrary. Because liposuction is so new, experience with the technique tends to count more than a doctor's specialization, so doctors whose total exposure to the procedure is a weekend course are not the safest bets no matter what their particular field.

Not for everyone. In general, liposuction works best on people under age 45 who have one or two isolated areas of "resistant" fat but are of normal weight for their body type. While the surgery can reshape a figure by removing a few pounds here and there, it won't remake it; your skirt size might drop a notch, but you won't look much better in a bikini. In fact, you may want to keep your newly slimmed area covered for at least eight weeks while the swelling and bruising caused by the sometimes violent procedure subsides. Liposuction's biggest plus is that the fat cells it takes away are gone forever. Overeating or lack of exercise can, however, put weight back into a liposuctioned area, by increasing the amount of fat stored in the remaining cells.

Medical experts agree that the hips, knees, lower abdomen and front and back of the upper legs are the areas most amenable to liposuction. Fat collects in these spots and is often hard to lose through exercise and dieting. The efficacy and safety of suctioning other areas of the body, however, remain a subject of debate. Some doctors, for example, routinely suction the buttocks. Others say that produces poor cosmetic results, since it is too easy to leave a misshapen or sunken buttock. Liposuction on the face and neck is gaining in popularity as an adjunct to facelifting. Some surgeons feel it is too risky. So you might want to keep your double chin and piano legs a while longer. Who knows? With so many people being suctioned down to size, a little extra meat just could come back into style. ■

A BUYER'S GUIDE TO COSMETIC SURGERY. *Checking into the body shop for a slimmer waistline, bigger bustline, more shapely nose or other type of cosmetic surgery is not without pain, expense and occasional risk. Although nearly all procedures can be done in a few hours on an outpatient basis, full recovery can take weeks or even months. Here's what to expect—*

Procedure	Doctor's fee (range)	Inpatient, outpatient	Time to perform procedure	General success and limitations	Risk of serious complications and the major types	Best candidates
Face and neck lift	**$3,000-$10,000**	**25%, 75%**	3-5 hours	Fair; only half look significantly younger. Effects generally last 5-10 years.	Less than 5%, from excessive bleeding, prolonged nerve injury. Lumpy scars behind the ears.	Nonsmokers age 50 and over with excessively wrinkled or sagging facial and neck skin.
Wrinkle removal (injections of collagen or silicone under the skin)	**$300-$1,500**	**0, 100%**	1-2 hours	Fair. Collagen lasts only about a year. Silicone is permanent, but long-term safety issues unclear.	Less than 3%, from allergic reaction to collagen. Mistakes with silicone are harder to resolve.	People with premature wrinkling and frown lines around eyes or lips, or with shallow acne scars.
Eyelid tuck, bag removal	**$1,500-$4,000**	**5%, 95%**	1-2 hours	Good. Won't fully eliminate wrinkles or bags. Skin may sag after 5 years.	Less than 5%. Thickened scar tissue, stretched look.	People age 35-65 with otherwise good skin tone.
Nose reshaping	**$2,000-$6,000**	**30%, 70%**	2-3 hours	Very good. Better success with bigger defects. Subtle corrections may be barely noticeable.	Less than 5%. Prolonged numbness and sinus infection, but little scarring.	Young and middle-aged people with an outsized, misshapen or "hump" nose.
Chin reshaping	**$750-$3,000**	**5%, 95%**	1-2 hours	Good. Will not improve alignment of teeth.	Less than 5%, from shifting implant or infection. Small scar underneath chin.	Young and middle-aged people with noticeably "weak" or inset chins.
Hair transplant	**$2,000-$10,000**	**2%, 98%**	1-3 hours (may require several procedures)	Good. Won't make hair grow or thicken existing hair.	Less than 5%. The more being transplanted, the greater the risk of unsatisfactory results.	Young and middle-aged dark-haired men with small bald areas and ample hair for transplanting.
Breast enlargement	**$2,000-$4,000**	**7%, 93%**	2-3 hours	Good. But 1 in 4 procedures will result in abnormal firmness or shape.	Less than 5%. Hardening or hard pockets that require implant replacement.	Women in their 20s and early 30s with small but not sagging breasts.
Breast lift	**$1,500-$6,000**	**25%, 75%**	2-3 hours	Good, short term; breasts may sag again after 5 years.	Less than 5%. Permanent scarring below the nipple; possible loss of nipple sensation.	Young women whose breasts have sagged or lost significant volume after childbearing and nursing.
Tummy tuck	**$2,000-$6,000**	**90%, 10%**	2-4 hours	Good. Will not remove very large amounts of fat or stretch marks.	Less than 10%, from poor healing and excessive scarring. Misplaced navel biggest worry.	Middle-aged people with normal weight who have droopy abdominal skin.
Liposuction	**$750-$4,000**	**25%, 75%**	1-2 hours, depending on body area	Good. Ineffective on elderly or very obese people or on large concentrations of fat. About 10% of patients may need resuctioning.	Less than 10%, from infection, fluid loss, and blood clots that can interrupt blood flow to vital organs.	Young and middle-aged people with good skin and muscle tone and localized fat resistant to dieting or exercise.

USN&WR—Basic data: The American Society of Plastic and Reconstructive Surgeons; *More Than Just a Pretty Face* by Dr. Thomas Rees with Sylvia Simmons; *The Complete Book of Cosmetic Surgery* by Dr. Elizabeth Morgan; *The Unfavorable Result in Plastic Surgery*, Vols. 1 and 2, edited by Dr. Robert M. Goldwyn

Recovery time
Full head bandages removed in a few days. Swelling and skin discoloration up to 3 weeks; tightness or numbness of face and neck up to 6 weeks. Limited sun exposure for 3 months.
Skin redness, swelling and minor bruising may persist for 7-10 days.
Presentable in public in 10 days. Swelling and discoloration may last 6-8 weeks; sensitive skin around eyes for a few months.
Splint for a week; back to work in 2 weeks. Difficulty breathing. Bruising around eyes for up to 3 weeks; swelling may not recede entirely for several months.
Discomfort for up to a week. Swelling for 2 weeks; stiffness up to 6 weeks.
Stitches out in a week. Hair growth from transplants in 3-4 months. Scarring noticeable until growth begins.
Swelling, excessive firmness, discoloration and loss of nipple sensitivity for a few weeks to 2 months.
Swelling and discoloration around stitches for up to a week. Stitches removed at 10 days to 2 weeks. Reduced sensation for up to a month. Special bra required for a month.
Hospital stay 2-3 days. Restricted activities for up to 6 weeks. Special garment required for 2-3 months.
Bandages off in 7-10 days. Numbness, bruising and swelling may last 6-8 weeks. Girdle may be necessary for 2-3 months.

After. *New Yorker Leona Zions, 53, decided to have her face lifted and nose reshaped last year after catching an unflattering glimpse of herself in a store window*

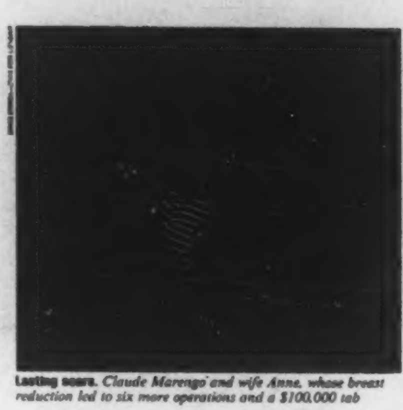
office is examining ads run by California plastic surgeons to determine whether they are misleading. The ASPRS has long pressed the Federal Trade Commission to establish advertising guidelines for the profession, but the agency has never acted. Wyden's subcommittee hopes to light a fire under the agency to do so.

Advertising is not the only questionable trend. Some doctors are pushing "preventive" surgery. They argue that getting a facelift, for example, *before* you actually need it, allows faster healing and better results than if you wait. That is bunk, says Harvard's Robert Goldwyn; a surgeon cannot lift a face that doesn't need lifting. Unscrupulous surgeons also may try to talk you into unnecessary procedures—a facelift and chin job, say, at the same time you get your nose fixed. Such multiple surgery can be in the patient's best interests. For example, surgeons often perform eyelid surgery or a chemical peel, in which facial skin is chemically treated to remove wrinkles, at the same time they do a facelift. Liposuction is also being more widely used to trim fat on the face and neck before a facelift. But someone interested in a nose job whose doctor urges liposuction on the thighs should be wary.

Before. *Leona Zions without the nips and tucks*

The biggest fear, shared by patients and doctors, is of a job that is botched, producing life-threatening complications, scarred breasts or a mutilated face. While the proportion of truly bad work has declined over the years, so many more people are having plastic surgery that the number of disasters has been slowly rising. Predictably, inexperienced doctors get the blame.

In 1974, for example, Anne Marengo went to a doctor whose work she had read about in a national women's magazine to have the size of her breasts reduced. Several weeks later, a serious infection took hold, and the flesh of one breast began to crumble and die. The surgeon, who had had no formal training in plastic surgery, operated again to try to save the breast. But the infection persisted, and the breast had to be removed. Told reconstruction was impossible, Marengo despaired. "It ruined my life; if I didn't have a supportive husband, I don't know what I would have done," she says. Eventually, Marengo found doctors willing to reconstruct the breast, but a half-dozen operations over 10 years left "godawful" scars and cost almost $100,000, only about half of which was covered by insurance. Marengo had another operation last February 9, her 50th birthday, and says the results are the best so far.



Lasting scars. *Claude Marengo and wife Anne, whose breast reduction led to six more operations and a $100,000 tab*

Such horror stories are sobering. But it is also true, according to various studies, that board-certified plastic surgeons make most of the serious mistakes because they do more operations. They also get sued just as often as physicians who lack certification. And beyond the nightmarish accounts, there are other less well-known, but more common, difficulties and limitations of plastic surgery. Enlarging the breasts with silicone implants, for example, is straightforward. An incision is made at the crease of the breast, a silicone-filled bag is inserted on top of or underneath the chest muscle and the bag is sewn in place. The breasts always end up larger. But about a quarter of women who undergo this procedure find their breast shape and size afterward is not what they hoped for. There is a 1-in-5 risk, moreover, of capsular contracture, a problem in which scar tissue forms around the implant and one or both breasts become overly firm. Further surgery may be needed to correct it. Doctors also argue about the possibility that breast implants make it harder for mammography to detect potentially cancerous lumps, though special X-ray techniques can minimize the problem. And questions persist about the long-term safety of the implants. Despite more than a decade of experience indicating no problems, the Food and Drug Administration is trying to determine whether leakage of silicone into the body is a bigger worry than has been thought.

Facelift failings

Facelifts, too, have limitations. While some hold up for seven or even 10 years, others may not last three years before a repeat procedure is needed. This can be due to a surgeon's unskilled hand but more often has to do with the patient's skin tone, age and lifestyle. Smokers, for instance, generally have poorer results because their skin is less elastic. On older people with poor skin tone, a facelift can leave the skin looking stretched and unnatural. Fixing bags under the eyes is a relatively simple

PICKING THE RIGHT DOCTOR

HOW TO MEASURE A SURGEON'S SKILL

"There is no such thing as minor surgery, only minor surgeons," quips Dr. Norman Hugo, former president of the American Society of Plastic and Reconstructive Surgeons (ASPRS). His remark has a serious edge. As more doctors trained in other medical specialties get into plastic surgery, patients have to take special care to choose a qualified surgeon. Doctors who switch may have only a year or two of training in plastic surgery; those who start out in the field, by contrast, have completed four or five-year surgical residencies.

Even the credentials of a doctor who comes highly recommended should be checked. Generally, you will want the doctor to be "board certified" as a plastic surgeon by the American Board of Plastic Surgery (ABPS) in Philadelphia, reachable at (215) 568-4000. Other medical boards, including the American Board of Cosmetic Surgery and the American Board of Otolaryngology, certify doctors who perform plastic surgery. And in some instances you may want to choose those doctors. But the ABPS is the only board recognized by the American Board of Medical Specialties, the oversight agency for medical boards in the United States. Doctors certified by the ABPS must have had five years of training in surgery and plastic surgery after medical school and been in practice for at least two years. None of the boards will recommend a doctor to you, however.

Doing the homework. Since it's wise to interview several plastic surgeons, you may benefit by getting additional names from the ASPRS. Its referral service, which can be reached at (800) 635-0635, will give you the names of 10 doctors in your area, all certified by the ABPS. The California Society of Plastic Surgeons operates its own referral service, reachable at (800) 722-2777. You can get names of members of the American Academy of Facial Plastic and Reconstructive Surgery by calling (800) 332-3223. These doctors are certified in ear, nose and throat medicine but specialize in facial plastic surgery.

Your comparison of doctors should figure in how frequently and for how many years each has performed the procedure you want done. A doctor who has built his reputation on breast implants may do far fewer facelifts. Even if your surgery is to be performed in the doctor's office, ask about hospital-surgery privileges. A lack of privileges may indicate that this doctor does not have the confidence of his or her peers. You should also be alert for other warning signs:

- A doctor who urges you to consider additional cosmetic procedures.
- One who relies on sensational ads.
- One who offers a supposedly cut-rate price.
- One who has been successfully sued. Suit records are generally on file in local courthouses.
- One who flaunts before-and-after photos of patients. They are an unreliable measure of a surgeon's skill. ■

procedure, but even when the surgeon is skilled, the shape and expression of the eyes are often subtly changed.

Some patients are unpleasantly surprised by how long it takes for swelling to go down and for them to get used to their new look. "It took a year to feel completely comfortable," says Stephanie Escamilla, 21, whose nose job almost three years ago removed a prominent bump. "But I'd do it again in a minute." It generally takes six months to a year for *all* effects of surgery to go away.

The best plastic surgeons will go out of their way to explain what you will go through. But many may not fill you in completely. They avoid emphasizing the negative for fear of scaring you off. Two patients who developed complications after plastic surgery told the congressional hearing last month that their doctors never informed them that things could go so badly awry. A survey by the state of Maryland found that most patients inquiring about breast enlargement were ill informed about the possible risks and limitations. As the result of legislation, Maryland plastic surgeons must now give interested women a brochure written by the state. Other states may soon follow suit, though doctors' groups lobby hard against the idea. In the meantime, your recourse is to ask questions and do as much homework as possible. The ASPRS produces short brochures on the various cosmetic procedures. But you may also want to look at a surgical textbook in a medical library to see how an operation is done. There is also a handful of excellent books for the lay public. Among the best are *More Than Just a Pretty Face* by Dr. Thomas Rees with Sylvia Simmons (Little, Brown, 1987), *The Complete Book of Cosmetic Surgery* by Dr. Elizabeth Morgan (Warner Books, 1988) and *The Face Book: The Pros and Cons of Facial Plastic Surgery*, by the American Academy of Facial Plastic and Reconstructive Surgery (Acropolis Books, 1988). All cost $19.95.

Most patients are not out to look like Hollywood celebrities. They will settle for fixing that irksome blemish and looking a bit younger or thinner. And the results usually are good. But greedy and poorly trained doctors are happy to operate on patients seeking a physical fix for a psychological problem. The mirror should not be the only guide. ■

Mixed bag. *John Hunter is happy that surgery minimized a scar on his forehead. He also had a facelift and chin implant*

by Steven Findlay

DECIDING WHETHER TO CUT

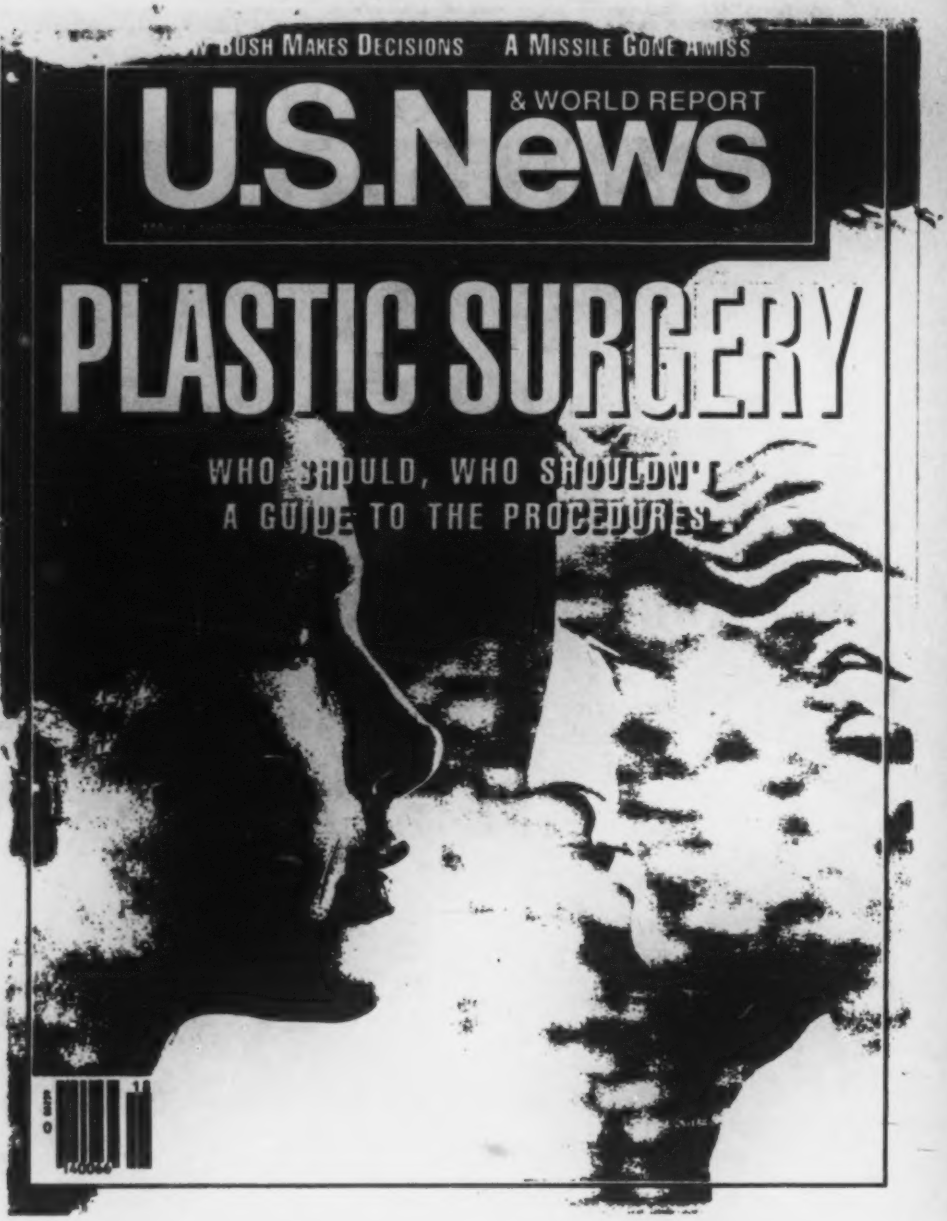
WILL SURGERY MAKE YOU HAPPY?

Physically, you might be a perfect candidate for plastic surgery. You have no health problems that make the procedure risky and have the precise kind of blemish that responds to a surgeon's knife. But psychologists and plastic surgeons say emotional dynamics must be considered, too. A person who hopes that a straighter nose or a fuller bust line will jump-start a stalled love life or provide lift to a flagging career is virtually sure to be disappointed. "By itself, cosmetic surgery won't make you happy, popular or successful. It won't save a marriage or career, and it probably won't change other people's opinion of you," says psychologist Mary Ruth Wright, who counsels cosmetic-surgery patients at the Baylor College of Medicine in Houston.

The best candidates for cosmetic surgery, in fact, are people who are generally content with their looks and their lives. They are opting for surgery not in response to some vague, overarching sense of inadequacy but because one or two specific parts of their anatomy have long made them feel conspicuous or uncomfortable—and a surgeon agrees that success is very likely. They have realistic expectations, too. "Unattractive people aren't going to be made beautiful," says Los Angeles plastic surgeon John Williams.

Imaginary imperfections. Many of those who head for the surgeon's office do not even have a realistic image of what it is they want fixed. Michael Kalick, a psychologist at the University of Massachusetts, says people who developed feelings of inadequacy as children when they were taunted about a big nose, small breasts, jug ears or baby fat often carry those debilitating feelings into adulthood even when their anatomical proportions have evened out nicely. For example, a woman who was teased about her flat chest as a teenager may seek breast implants even though she has grown into a shapely adult, because she is still plagued by the conviction that she is unattractive. Even the slenderest woman, obsessed with her weight as an adolescent, may be convinced she is fat. But an imaginary waistline problem is unlikely to be much improved, even assuming that an unscrupulous doctor agrees to do a tummy tuck. Kalick thinks such people are better served by coming to terms with their feelings than by surgery. Moreover, an operation is probably not worth the risk, however small, of complications.

A reputable surgeon will also discourage you if your desire for change seems to be motivated by the body mode of the moment, since you won't be able to update your look as fashions change. Breast reduction had a heyday while the Twiggy look was in vogue. Now, fuller breasts are in, and breast enlargement is popular. While people bent on transformation may find a physician to perform almost any operation, for many surgery simply cannot bring about the change that is really desired. ■



W BUSH MAKES DECISIONS A MISSILE GONE AMISS

U.S.News & WORLD REPORT

PLASTIC SURGERY

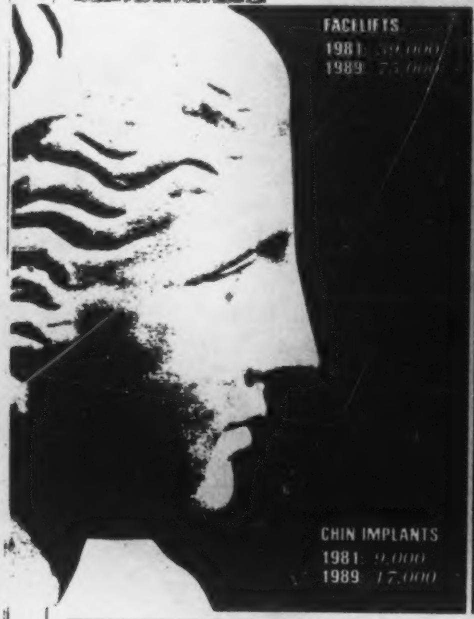
WHO SHOULD, WHO SHOULDN'T

A GUIDE TO THE PROCEDURES

NEWS YOU CAN USE

BUYING THE PERFECT BODY

New and better techniques have made cosmetic plastic surgery more popular, more convenient and generally safer. But not necessarily risk-free. Or wiser


FACELIFTS
1981: [illegible]
1989: 75,000
CHIN IMPLANTS
1981: 9,000
1989: 17,000

EYELID TUCKS
1981: 56,000
1989: 100,000

With Susan, it was her knees. "They drove me crazy," says the 28-year-old waitress and aspiring actress in Los Angeles. "There was too much fat around them. My nose had a bump I didn't like. . . . And my breasts just didn't fit with the rest of me." So last February, in a single procedure, a surgeon suctioned away the fat around Susan's knees, excised the bump on her nose and implanted a fist-size bag of silicone gel in both breasts. Exults Susan: "This is what I should have been born looking like."

John Hunter, 54, originally sought plastic surgery to remove a birthmark and scar from his forehead but elected to have a facelift, eyelid surgery and a chin implant at the same time. "It wasn't that I thought I was ugly or that I lacked self-confidence," says the chairman of a Florida-based computer-design firm. "I just wanted to feel better about the way I looked, and it worked."

Once ridiculed as neurotically narcissistic and never a topic for public revelation, cosmetic plastic surgery has become positively trendy. Celebrities who proudly display new faces, noses, lips and breasts seem to have persuaded hundreds of thousands of other Americans that getting their noses bobbed and chins cleft, tummies tucked and upper legs suctioned of fat is no more worthy of serious concern than having a tooth filled. An estimated 750,000 people had cosmetic surgery in 1988, compared with 300,000 in 1981, and that only counts procedures performed by certified plastic surgeons. The total number of operations is likely around 1.5 million, since an increasing number of doctors uncertified in plastic surgery are also now doing cosmetic procedures. An estimated half-million others underwent hair transplants or had collagen injected beneath their skin to smooth wrinkles or plump out lips.

Nurtured on instant gratification, baby-boomers are once again at this latest cutting edge. "I have 35-year-old women coming in for facelifts," says Dr. Robert Goldwyn, a Boston plastic surgeon. And Dr. Susan Chobenian, a Beverly Hills plastic surgeon, reports: "Women who have perfectly nice full-sized breasts ask me if I can make them even larger. It's crazy. I tell many of them no, but I know they can get it done somewhere else." With the stigma reduced, more men, too, are lining up. A quarter of all nose jobs, 10 percent of facelifts and 18 percent of eye procedures are now done on men.

Why diet?

Liposuction, a relatively new technique, is what has drawn in most of the young. Developed in France and imported to the U.S. in the early 1980s, liposuction, which removes fat, is now the most common cosmetic procedure. Too often, critics say, it's used as a substitute for dieting and exercise (see box, page 68).

Advances in cosmetic and reconstructive plastic surgery in the last decade have made the most common procedures safer, better and more convenient, if not cheaper. Facelifts, for example, used to

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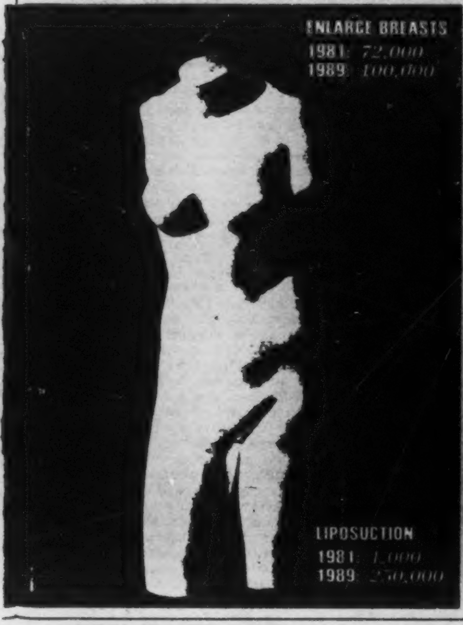
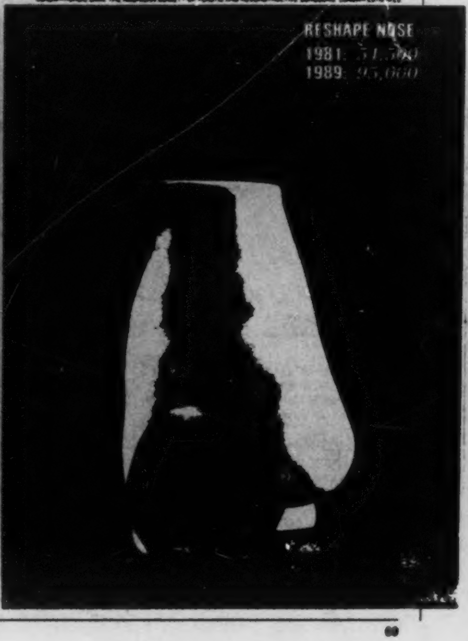
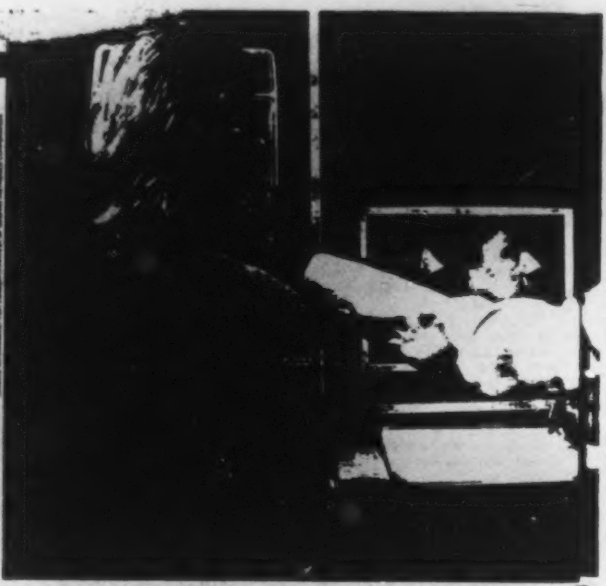




merely tighten the skin of the face, with results rarely lasting beyond two or three years. Doctors now perform a much more elaborate procedure, removing fat and shifting muscles as well as tightening the skin. The result now lasts five to seven years. New techniques allow surgical repair of birth deformities and accident-related injuries that was not possible 10 or 15 years ago. Advances in microsurgery and bone resculpting make reattached limbs look more natural. Improved skin-graft techniques save thousands every year from hideous burn scars. Breast reconstruction following a mastectomy eases some of the psychological scarring. And newer methods are being developed, such as bone grafts to build up misshapen features and computers that can redesign a patient's face before doctors make the first incision. In-office computer videos allow surgeons to show patients alternatives and what to expect. A nose, for example, can be displayed in various shapes and sizes.



Better results, troubling ethics

The advances have meant techniques that used to yield fairly high rates of poor results have been supplanted by methods that produce good to excellent cosmetic results for 85 to 95 percent of patients (see table, page 70). In addition, the 1 to 5 percent rate of serious complications for common cosmetic procedures is no greater than for most other forms of major surgery.

But the land of nip and tuck faces troubling ethical questions as the popularity of cosmetic surgery soars. Are too many people with minor physical flaws, or perhaps no obvious flaws at all, choosing plastic surgery? Is the preoccupation with physical appearance in our culture healthy? "I don't think so," says Harvard's Goldwyn, author of *Beyond Appearance: Reflections of a Plastic Surgeon* (Dodd, Mead & Company, 1986, $16.95). "It troubles me. There are more people getting cosmetic surgery today than perhaps should be."

Many surgeons clearly are not discriminating carefully between good and bad candidates for surgery. The sheer glut of doctors practicing plastic surgery is one reason. A growing number of new physicians are choosing cosmetic surgery because it's such a lucrative specialty and because patients pay cash, usually up front; most procedures are not covered by health insurance.

THE SIMPLISTIC LURE OF LIPOSUCTION

UNLOADING THOSE SADDLEBAGS FOR GOOD

Plastic surgeons call it "diet-and-exercise-resistant fat." But most people know those unshrinkable blobs of blubber as love handles, saddlebags and spare tires. These unwelcome extras have become the targets of liposuction, a surgical technique that literally sucks fat out from under the skin with a pencil-thin, foot-long metal probe attached to a pump. Since liposuction was introduced in the U.S. in 1981, it has become the hottest form of cosmetic surgery. An estimated 150,000 people had liposuction last year, and the number is expected to climb to 250,000 in 1989.

Although the procedure is generally considered safe and effective, its raging popularity belies the fact that it cannot produce miracles and can be deadly if done improperly. At least 11 liposuction patients have died from such complications as infection, fluid loss and blood clots. Countless others have ended up with rippled "washboard" skin and other undesirable results at the hands of poorly trained practitioners. "Three or four weeks after surgery, my right leg sort of caved in, my knee swelled up and I could not bend my leg," Angela Brown of Bowie, Md., told a recent congressional hearing on the hazards of plastic surgery. Her doctor had taken out too much fat when trimming down her thighs, leaving a sunken pocket of flesh that clung to the muscle, a condition that can be very difficult to correct. Another plastic surgeon advised Brown, 42, to undergo fat transplantation, a still experimental procedure, to fill in the depression. Fat from her abdomen, left leg and arms was transferred to her right leg. But even that was only partially successful, leaving Brown with a noticeable indentation. She now warns prospective patients that "liposuction is surgery and things can go wrong."

Warning sounded. The craze for a quick fat fix among women, who make up about 90 percent of liposuction patients, shows no signs of abating. And the immensely lucrative procedure has lured so many doctors to take up the craft that virtually anyone who wants liposuction can get it. A committee of the American Society of Plastic and Reconstructive Surgeons (ASPRS), the leading group of its kind,

Crystal ball. *By using a special computer, Dr. Oscar Ramirez gives Lorraine Smith, 43, a sneak preview of her future face. The image on the left is Smith's preoperative profile; the one on the right is her profile after a facelift and nose job. Smith knew just what to expect when her bandages came off last week.*

Perhaps more important, it has lured practitioners away from other specialties. The House subcommittee on Regulation, Business Opportunities and Energy held hearings on cosmetic surgery last month and concluded after a six-month probe that it was too easy for doctors whose primary training lay in other medical fields to set up a practice in plastic surgery. Liposuction was the most common procedure done by those untrained in plastic surgery. In one case, a woman died and one was severely injured after undergoing liposuction by a Texas gynecologist untrained in the technique. But other procedures, too, according to the findings, were being done by doctors who had switched, most often from emergency medicine, general surgery or ear, nose and throat medicine. The committee recommended that state medical boards step up efforts to regulate who should be allowed to perform plastic surgery. "Too many hucksters are out there just to make a fast buck," says Representative Ron Wyden (D-Oreg.), chairman of the subcommittee.

Meanwhile, more doctors doing cosmetic surgery means stiffer competition for patients. This translates into less willingness on the part of many plastic surgeons to say no to patients who may have little need for cosmetic surgery or who may be poor candidates psychologically (see box, page 73).

Many plastic surgeons, in fact, have mounted aggressive advertising campaigns to recruit patients. Perhaps the most notorious ad to date, appearing in *LA Magazine*, is an eight-page foldout that highlights a buxom woman in a bathing suit standing next to a sleek sports car and, in large type, the words: "Automobile by Ferrari. Body by Forshan." The reference is to Dr. Vincent Forshan, a plastic surgeon in Rancho Mirage, Calif. The ad extols not only Forshan's surgical skill but his "beautifully appointed examination rooms . . . with Joan Miró prints and color-coordinated reclining power tables."

The hype factor

It turned out that Forshan had never worked on the model in the ad and did not know that another plastic surgeon—Dr. Charles Smithdeal of Los Angeles—had. Smithdeal was not happy about what he called false advertising. Forshan argued that the ads didn't say *that* woman's body and now says, "We never meant to mislead anyone." In a later issue of *LA Magazine*, Smithdeal appears to have had the last word, or ad, with the same model posing next to another red Ferrari, along with the message: "Body by Smithdeal."

Dr. Norman Hugo, immediate past president of the American Society of Plastic and Reconstructive Surgeons (ASPRS), is exasperated by the squabbling and by the hype that occasioned it. "This ad and so many others like it are aimed at undecided people. That's O.K. when you're selling cars or appliances but not to sell surgery," he says. Plastic surgeons who advertise disagree. "I don't think anybody makes a decision to have surgery on the basis of an ad," says Dr. John Williams of Aesthetica, a Center for Aesthetic Plastic Surgery in Los Angeles. "It brings a few patients in the door. After that, the same careful consultation occurs." The California attorney general's said in a 1987 report that the technique was being overused largely because "inadequately trained surgeons" were operating on poor candidates for the procedure. The report singled out extremely obese individuals, who do not benefit from the relatively few pounds that can be removed by liposuction, and people whose weight problems could be solved other ways. A woman who is 10 to 15 pounds overweight and has not sincerely dieted or exercised should not be slated for liposuction, doctors say, but many people are having the procedure anyway.

The ASPRS, of course, advises having liposuction done only by a board-certified plastic surgeon. But other medical specialists, such as dermatologists, argue that they produce equally good results, and there is no evidence to the contrary. Because liposuction is so new, experience with the technique tends to count more than a doctor's specialization, so doctors whose total exposure to the procedure is a weekend course are not the safest bets no matter what their particular field.

Not for everyone. In general, liposuction works best on people under age 45 who have one or two isolated areas of "resistant" fat but are of normal weight for their body type. While the surgery can reshape a figure by removing a few pounds here and there, it won't remake it; your skirt size might drop a notch, but you won't look much better in a bikini. In fact, you may want to keep your newly slimmed area covered for at least eight weeks while the swelling and bruising caused by the sometimes violent procedure subsides. Liposuction's biggest plus is that the fat cells it takes away are gone forever. Overeating or lack of exercise can, however, put weight back into a liposuctioned area, by increasing the amount of fat stored in the remaining cells.

Medical experts agree that the hips, knees, lower abdomen and front and back of the upper legs are the areas most amenable to liposuction. Fat collects in these spots and is often hard to lose through exercise and dieting. The efficacy and safety of suctioning other areas of the body, however, remain a subject of debate. Some doctors, for example, routinely suction the buttocks. Others say that produces poor cosmetic results, since it is too easy to leave a misshapen or sunken buttock. Liposuction on the face and neck is gaining in popularity as an adjunct to facelifting. Some surgeons feel it is too risky. So you might want to keep your double chin and piano legs a while longer. Who knows? With so many people being suctioned down to size, a little extra meat just could come back into style. ■

A BUYER'S GUIDE TO COSMETIC SURGERY. *Checking into the body shop for a slimmer waistline, bigger bustline, more shapely nose or other type of cosmetic surgery is not without pain, expense and occasional risk. Although nearly all procedures can be done in a few hours on an outpatient basis, full recovery can take weeks or even months. Here's what to expect—*

Procedure	Doctor's fee (range)	Inpatient, outpatient	Time to perform procedure	General success and limitations	Risk of serious complications and the major types	Best candidates
Face and neck lift	**$2,000-$10,000**	**25%, 75%**	3-5 hours	Fair; only half look significantly younger. Effects generally last 5-10 years.	Less than 5%, from excessive bleeding, prolonged nerve injury. Lumpy scars behind the ears.	Nonsmokers age 50 and over with excessively wrinkled or sagging facial and neck skin.
Wrinkle removal (injections of collagen or silicone under the skin)	**$200-$1,500**	**0, 100%**	1-2 hours	Fair. Collagen lasts only about a year. Silicone is permanent, but long-term safety issues unclear.	Less than 3%, from allergic reaction to collagen. Mistakes with silicone are harder to resolve.	People with premature wrinkling and frown lines around eyes or lips, or with shallow acne scars.
Eyelid tuck, bag removal	**$1,500-$4,000**	**5%, 95%**	1-2 hours	Good. Won't fully eliminate wrinkles or bags. Skin may sag after 5 years.	Less than 5%. Thickened scar tissue, stretched look.	People age 38-55 with otherwise good skin tone.
Nose reshaping	**$2,000-$6,000**	**30%, 70%**	2-3 hours	Very good. Better success with bigger defects. Subtle corrections may be barely noticeable.	Less than 5%. Prolonged numbness and sinus infection, but little scarring.	Young and middle-aged people with an outsized, misshapen or "hump" nose.
Chin reshaping	**$750-$3,000**	**5%, 95%**	1-2 hours	Good. Will not improve alignment of teeth.	Less than 5%, from shifting implant or infection. Small scar underneath chin.	Young and middle-aged people with noticeably "weak" or inset chins.
Hair transplant	**$2,000-$10,000**	**2%, 98%**	1-3 hours (may require several procedures)	Good. Won't make hair grow or thicken existing hair.	Less than 5%. The more being transplanted, the greater the risk of unsatisfactory results.	Young and middle-aged dark-haired men with small bald areas and ample hair for transplanting.
Breast enlargement	**$2,000-$4,000**	**7%, 93%**	2-3 hours	Good. But 1 in 4 procedures will result in abnormal firmness or shape.	Less than 5%. Hardening or hard pockets that require implant replacement.	Women in their 20s and early 30s with small but not sagging breasts.
Breast lift	**$1,500-$5,000**	**25%, 75%**	2-3 hours	Good, short term; breasts may sag again after 5 years.	Less than 5%. Permanent scarring below the nipple; possible loss of nipple sensation.	Young women whose breasts have sagged or lost significant volume after childbearing and nursing.
Tummy tuck	**$2,000-$6,000**	**90%, 10%**	2-4 hours	Good. Will not remove very large amounts of fat or stretch marks.	Less than 10%, from poor healing and excessive scarring. Misplaced navel biggest worry.	Middle-aged people with normal weight who have droopy abdominal skin.
Liposuction	**$750-$4,000**	**25%, 75%**	1-2 hours, depending on body area	Good. Ineffective on elderly or very obese people or on large concentrations of fat. About 10% of patients may need resuctioning.	Less than 10%, from infection, fluid loss, and blood clots that can interrupt blood flow to vital organs.	Young and middle-aged people with good skin and muscle tone and localized fat resistant to dieting or exercise.

SOURCES—Basic data: The American Society of Plastic and Reconstructive Surgeons; *More Than Just a Pretty Face* by Dr. Thomas Rees with Sylvia Simmons; *The Complete Book of Cosmetic Surgery* by Dr. Elizabeth Morgan; *The Unfavorable Result in Plastic Surgery*, Vols. 1 and 2, edited by Dr. Robert M. Goldwyn

Recovery time
Full head bandages removed in a few days. Swelling and skin discoloration up to 3 weeks; tightness or numbness of face and neck up to 6 weeks. Limited sun exposure for 3 months.
Skin redness, swelling and minor bruising may persist for 7-10 days.
Presentable in public in 10 days. Swelling and discoloration may last 6-8 weeks; sensitive skin around eyes for a few months.
Splint for a week; back to work in 2 weeks. Difficulty breathing. Bruising around eyes for up to 3 weeks; swelling may not recede entirely for several months.
Discomfort for up to a week. Swelling for 2 weeks; stiffness up to 6 weeks.
Stitches out in a week. Hair growth from transplants in 3-4 months. Scarring noticeable until growth begins.
Swelling, excessive firmness, discoloration and loss of nipple sensitivity for a few weeks to 2 months.
Swelling and discoloration around stitches for up to a week. Stitches removed at 10 days to 2 weeks. Reduced sensation for up to a month. Special bra required for a month.
Hospital stay 2-3 days. Restricted activities for up to 6 weeks. Special garment required for 2-3 months.
Bandages off in 7-10 days. Numbness, bruising and swelling may last 6-8 weeks. Girdle may be necessary for 2-3 months.

After. *New Yorker Leona Zions, 53, decided to have her face lifted and nose reshaped last year after catching an unflattering glimpse of herself in a store window*

office is examining ads run by California plastic surgeons to determine whether they are misleading. The ASPRS has long pressed the Federal Trade Commission to establish advertising guidelines for the profession, but the agency has never acted. Wyden's subcommittee hopes to light a fire under the agency to do so.

Advertising is not the only questionable trend. Some doctors are pushing "preventive" surgery. They argue that getting a facelift, for example, *before* you actually need it, allows faster healing and better results than if you wait. That is bunk, says Harvard's Robert Goldwyn; a surgeon cannot lift a face that doesn't need lifting. Unscrupulous surgeons also may try to talk you into unnecessary procedures—a facelift and chin job, say, at the same time you get your nose fixed. Such multiple surgery can be in the patient's best interests. For example, surgeons often perform eyelid surgery or a chemical peel, in which facial skin is chemically treated to remove wrinkles, at the same time they do a facelift. Liposuction is also being more widely used to trim fat on the face and neck before a facelift. But someone interested in a nose job whose doctor urges liposuction on the thighs should be wary.

Before. *Leona Zions without the nips and tucks*

The biggest fear, shared by patients and doctors, is of a job that is botched, producing life-threatening complications, scarred breasts or a mutilated face. While the proportion of truly bad work has declined over the years, so many more people are having plastic surgery that the number of disasters has been slowly rising. Predictably, inexperienced doctors get the blame.

In 1974, for example, Anne Marengo went to a doctor whose work she had read about in a national women's magazine to have the size of her breasts reduced. Several weeks later, a serious infection took hold, and the flesh of one breast began to crumble and die. The surgeon, who had had no formal training in plastic surgery, operated again to try to save the breast. But the infection persisted, and the breast had to be removed. Told reconstruction was impossible, Marengo despaired. "It ruined my life; if I didn't

Lasting scars. *Claude Marengo and wife Anne, whose breast reduction led to six more operations and a $100,000 tab*

have a supportive husband, I don't know what I would have done," she says. Eventually, Marengo found doctors willing to reconstruct the breast, but a half-dozen operations over 10 years left "godawful" scars and cost almost $100,000, only about half of which was covered by insurance. Marengo had another operation last February 9, her 50th birthday, and says the results are the best so far.

Such horror stories are sobering. But it is also true, according to various studies, that board-certified plastic surgeons make most of the serious mistakes because they do more operations. They also get sued just as often as physicians who lack certification. And beyond the nightmarish accounts, there are other less well-known, but more common, difficulties and limitations of plastic surgery. Enlarging the breasts with silicone implants, for example, is straightforward. An incision is made at the crease of the breast, a silicone-filled bag is inserted on top of or underneath the chest muscle and the bag is sewn in place. The breasts always end up larger. But about a quarter of women who undergo this procedure find their breast shape and size afterward is not what they hoped for. There is a 1-in-5 risk, moreover, of capsular contracture, a problem in which scar tissue forms around the implant and one or both breasts become overly firm. Further surgery may be needed to correct it. Doctors also argue about the possibility that breast implants make it harder for mammography to detect potentially cancerous lumps, though special X-ray techniques can minimize the problem. And questions persist about the long-term safety of the implants. Despite more than a decade of experience indicating no problems, the Food and Drug Administration is trying to determine whether leakage of silicone into the body is a bigger worry than has been thought.

Facelift failings

Facelifts, too, have limitations. While some hold up for seven or even 10 years, others may not last three years before a repeat procedure is needed. This can be due to a surgeon's unskilled hand but more often has to do with the patient's skin tone, age and lifestyle. Smokers, for instance, generally have poorer results because their skin is less elastic. On older people with poor skin tone, a facelift can leave the skin looking stretched and unnatural. Fixing bags under the eyes is a relatively simple

PICKING THE RIGHT DOCTOR

HOW TO MEASURE A SURGEON'S SKILL

"There is no such thing as minor surgery, only minor surgeons," quips Dr. Norman Hugo, former president of the American Society of Plastic and Reconstructive Surgeons (ASPRS). His remark has a serious edge. As more doctors trained in other medical specialties get into plastic surgery, patients have to take special care to choose a qualified surgeon. Doctors who switch may have only a year or two of training in plastic surgery; those who start out in the field, by contrast, have completed four or five-year surgical residencies.

Even the credentials of a doctor who comes highly recommended should be checked. Generally, you will want the doctor to be "board certified" as a plastic surgeon by the American Board of Plastic Surgery (ABPS) in Philadelphia, reachable at (215) 568-4000. Other medical boards, including the American Board of Cosmetic Surgery and the American Board of Otolaryngology, certify doctors who perform plastic surgery. And in some instances you may want to choose those doctors. But the ABPS is the only board recognized by the American Board of Medical Specialties, the oversight agency for medical boards in the United States. Doctors certified by the ABPS must have had five years of training in surgery and plastic surgery after medical school and been in practice for at least two years. None of the boards will recommend a doctor to you, however.

Doing the homework. Since it's wise to interview several plastic surgeons, you may benefit by getting additional names from the ASPRS. Its referral service, which can be reached at (800) 635-0635, will give you the names of 10 doctors in your area, all certified by the ABPS. The California Society of Plastic Surgeons operates its own referral service, reachable at (800) 722-2777. You can get names of members of the American Academy of Facial Plastic and Reconstructive Surgery by calling (800) 332-3223. These doctors are certified in ear, nose and throat medicine but specialize in facial plastic surgery.

Your comparison of doctors should figure in how frequently and for how many years each has performed the procedure you want done. A doctor who has built his reputation on breast implants may do far fewer facelifts. Even if your surgery is to be performed in the doctor's office, ask about hospital-surgery privileges. A lack of privileges may indicate that this doctor does not have the confidence of his or her peers. You should also be alert for other warning signs:

- A doctor who urges you to consider additional cosmetic procedures.
- One who relies on sensational ads.
- One who offers a supposedly cut-rate price.
- One who has been successfully sued. Suit records are generally on file in local courthouses.
- One who flaunts before-and-after photos of patients. They are an unreliable measure of a surgeon's skill. ■

procedure, but even when the surgeon is skilled, the shape and expression of the eyes are often subtly changed.

Some patients are unpleasantly surprised by how long it takes for swelling to go down and for them to get used to their new look. "It took a year to feel completely comfortable," says Stephanie Escamilla, 21, whose nose job almost three years ago removed a prominent bump. "But I'd do it again in a minute." It generally takes six months to a year for *all* effects of surgery to go away.

The best plastic surgeons will go out of their way to explain what you will go through. But many may not fill you in completely. They avoid emphasizing the negative for fear of scaring you off. Two patients who developed complications after plastic surgery told the congressional hearing last month that their doctors never informed them that things could go so badly awry. A survey by the state of Maryland found that most patients inquiring about breast enlargement were ill informed about the possible risks and limitations. As the result of legislation, Maryland plastic surgeons must now give interested women a brochure written by the state. Other states may soon follow suit, though doctors' groups lobby hard against the idea. In the meantime, your recourse is to ask questions and do as much homework as possible. The ASPRS produces short brochures on the various cosmetic procedures. But you may also want to look at a surgical textbook in a medical library to see how an operation is done. There is also a handful of excellent books for the lay public. Among the best are *More Than Just a Pretty Face* by Dr. Thomas Rees with Sylvia Simmons (Little, Brown, 1987), *The Complete Book of Cosmetic Surgery* by Dr. Elizabeth Morgan (Warner Books, 1988) and *The Face Book: The Pros and Cons of Facial Plastic Surgery*, by the American Academy of Facial Plastic and Reconstructive Surgery (Acropolis Books, 1988). All cost $19.95.

Mixed bag. *John Hunter is happy that surgery minimized a scar on his forehead. He also had a facelift and chin implant*

Most patients are not out to look like Hollywood celebrities. They will settle for fixing that irksome blemish and looking a bit younger or thinner. And the results usually are good. But greedy and poorly trained doctors are happy to operate on patients seeking a physical fix for a psychological problem. The mirror should not be the only guide. ■

by Steven Findlay

DECIDING WHETHER TO CUT

WILL SURGERY MAKE YOU HAPPY?

Physically, you might be a perfect candidate for plastic surgery. You have no health problems that make the procedure risky and have the precise kind of blemish that responds to a surgeon's knife. But psychologists and plastic surgeons say emotional dynamics must be considered, too. A person who hopes that a straighter nose or a fuller bust line will jump-start a stalled love life or provide lift to a flagging career is virtually sure to be disappointed. "By itself, cosmetic surgery won't make you happy, popular or successful. It won't save a marriage or career, and it probably won't change other people's opinion of you," says psychologist Mary Ruth Wright, who counsels cosmetic-surgery patients at the Baylor College of Medicine in Houston.

The best candidates for cosmetic surgery, in fact, are people who are generally content with their looks and their lives. They are opting for surgery not in response to some vague, overarching sense of inadequacy but because one or two specific parts of their anatomy have long made them feel conspicuous or uncomfortable—and a surgeon agrees that success is very likely. They have realistic expectations, too. "Unattractive people aren't going to be made beautiful," says Los Angeles plastic surgeon John Williams.

Imaginary imperfections. Many of those who head for the surgeon's office do not even have a realistic image of what it is they want fixed. Michael Kalick, a psychologist at the University of Massachusetts, says people who developed feelings of inadequacy as children when they were taunted about a big nose, small breasts, jug ears or baby fat often carry those debilitating feelings into adulthood even when their anatomical proportions have evened out nicely. For example, a woman who was teased about her flat chest as a teenager may seek breast implants even though she has grown into a shapely adult, because she is still plagued by the conviction that she is unattractive. Even the slenderest woman, obsessed with her weight as an adolescent, may be convinced she is fat. But an imaginary waistline problem is unlikely to be much improved, even assuming that an unscrupulous doctor agrees to do a tummy tuck. Kalick thinks such people are better served by coming to terms with their feelings than by surgery. Moreover, an operation is probably not worth the risk, however small, of complications.

A reputable surgeon will also discourage you if your desire for change seems to be motivated by the body mode of the moment, since you won't be able to update your look as fashions change. Breast reduction had a heyday while the Twiggy look was in vogue. Now, fuller breasts are in, and breast enlargement is popular. While people bent on transformation may find a physician to perform almost any operation, for many surgery simply cannot bring about the change that is really desired. ■

WASHINGTONIAN SEPTEMBER 1989

Salaries People Make • 100 Most Powerful Women

WASHINGTONIAN

Young Again!

Guide to Cosmetic Surgery, Facelifts, Liposuction, Breast Implants, and More—Plus Doctors Who Do It Well

[illegible] McLellan
Before and After
Tells the Story
of Her Facelift

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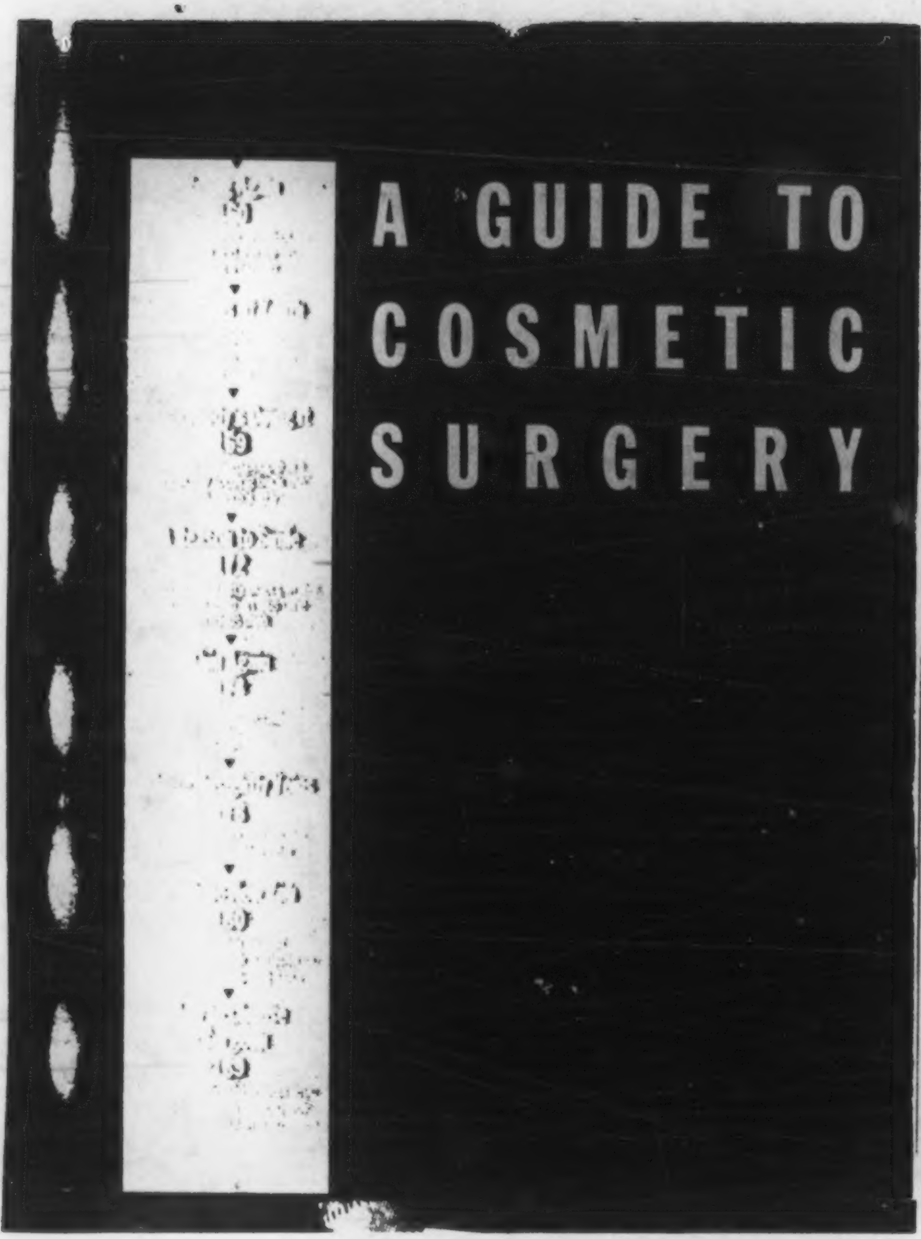


A GUIDE TO COSMETIC SURGERY

Work Up the Nerve,
Find a Good Plastic Surgeon,
Spend a Month Looking and Feeling Like Hell,
and You Too Can Be

Young Again!

By Diana McLellan

Strange men don't sidle up to me at the fish counter with questing eyes. The lifeguard hasn't asked me to run away with him. I haven't been propositioned by Teddy Kennedy, Richard Cohen, or even Carl Bernstein.

But do I ever look good.

After months of doubts and questions, after weeks of numb cheeks, bloodshot eyes, lumps, and swellings that turned my face into an ambulatory ugli fruit, I think I look terrific. My jowls are gone. My neck is, well, adorable. My eyes are, in the words of no less an authority than my own daughter, "sexy."

My husband is admiring. My friends are adulatory. My enemies ask why I didn't get a nose job while I was at it, but so what?

Best of all, my granddaughter hasn't noticed a thing.

What would she know about a facelift? For that matter, what did I know about a facelift when that little seed planted itself in my mind a year or so ago?

At some point, that little seed seems to plant itself in the mind of almost every woman. It can begin the moment you catch your reflection in a shop window—and think you've just spotted your mother. Or when a friend sends you the candid shots from the party, and you wonder, "Who's that woman with more chins than the Hong Kong phone book?"

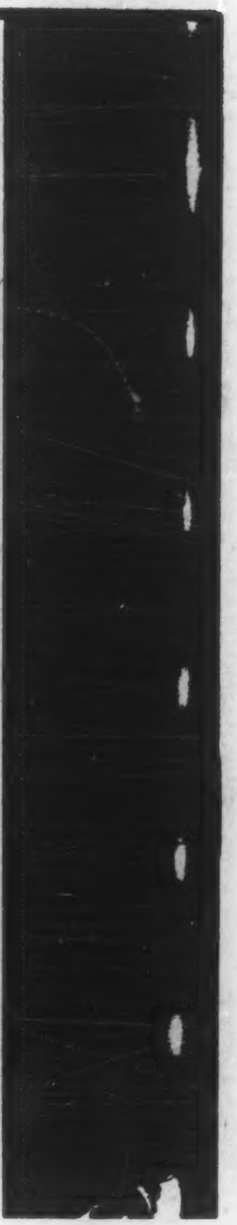
Or it can start in a strange powder room, the kind with lighting from hell, when suddenly the signs of long, hard mileage declare themselves in the mirror: the bags and wrinkles beneath the eyes, the droops above; the little pouch beneath the jaw that has evolved into a full-fledged jowl; the long ravines running from the corners of the mouth to the nostrils.

However it is planted, the seed is nourished by constant reminders that it needn't be so: Michael Landon and his wife getting matching facelifts for Valentine's Day; Jackie O. celebrating her 60th the same way; Joan Rivers keeping four plastic surgeons on hand—an eyebag man, a cheek-lift man, a fat-sucker, and a wrinkle-filler—and giving each member of her staff the plastic surgery of his or her choice for Christmas; Michael Jackson's bionic visage.

Then there are the statistics that herald the graying of the baby-boomers, the aging of the yups: Over 2 million Americans underwent plastic surgery in 1988—up from 590,550 in 1986. The incidence of liposuction, now the most popular form of plastic surgery for women, went up 80 percent in the last four years. And the number of men seeking plastic surgery went up more than a third.

For me, the seed grew quietly, solitarily, without a whisper to husband or child, surfacing only occasionally at those lunchtime conversations between girlfriends that have become a staple of the Washington landscape: Two women are talking intimately at a restaurant. One leans back and applies her thumbs and forefingers to the sides of her face—and lifts in a gesture she has perfected in her vanity mirror. Here is how she would look if, with a nip here and a tuck there, gravity's grim work of the past decade could be washed away.

But that's *before*. After the Washington woman gets her facelift, she clams up. I know women who blab about their husband's incomes, their current affairs, the condition of their internal organs, and the price of their vaca-



Dr. John William Little III, director of Plastic Surgery at Georgetown University Medical Center, points out the incision line on his patient, Diana McLellan. This photo was taken fourteen weeks after her facelift.

This patient's "after" photograph was taken six weeks following a face- and neck-lift, with some sculpting of the fat of the neck, as well as lifting of the brows, upper and lower eyelids, lips, and corners of the mouth, and dermabrasion (light sanding) around the mouth.

tion homes—but of their debt to the scalpel, only their plastic surgeons and their hairdressers know for sure.

Yet, as I recently found out, the ambassador's wife, the protocol chief, the Democratic fund-raising doyenne, the famous reporter, the woman lobbyist, the Cabinet wife—every face in moderately public life that suddenly looks "rested"—has more than a good night's sleep to thank. But these people will discuss the matter only with other alumnae of the knife—and sometimes not even then.

A journalist, I figured, should be able to find out something about it all. The corollary to this thought, as it dawned, was transfixing: A journalist should be able to have her face lifted, have it paid for, get paid for doing it, bring the big secret out of the closet, and serve Washington womankind, herself, and her beloved publication all at once.

Project Young Again was under way.

My husband's first reaction was revulsion. Then a ringing "No!"

"I love you just the way you are," he declared.

As one who has always scorned wifely wiles, I'm rather proud of the way I eased him into accepting the inevitable. I launched a campaign, casually pointing out the beauties of those who had been tucked. I left snapshots around of myself with jowls in full flower. Meanwhile, I probed for his real objections.

His greatest fear was that I would die under the knife. After that, he worried that something would go wrong—that he would wake up each morning for the rest of his life beside a sort of Phantom of the Opera—scarred, perhaps paralyzed, definitely pitiable.

I had at this point done enough research to be able to dispel his most pressing fears, and it was then that he dropped the seven words that told me my battle was won: "Of course," he remarked, "*I don't want you to look old.* . . ."

What husband does? I dug into my research and began to nail down some specifics.

The Face Book: The Pros and Cons of Facial Plastic Surgery, prepared by the American Academy of Facial Plastic and Reconstructive Surgery (published in 1988 by Acropolis) was a helpful primer. It laid out the things a novice needs to know: realistic expectations of the results; which types of skins scar most and least (generally, the fairer the skin the less heavy the scarring); explicit descriptions of different types of plastic surgery of the face and neck, complete with before and after shots. Perhaps the most useful chapter is on finding a plastic surgeon—basing your choice on recommendations from former patients, medical referrals, and, most interesting, hairdressers and cosmeticians, who, after all, see the results more intimately than almost anyone else.

After much research and meditation I settled on Dr. John William Little III, director of the division of plastic surgery at Georgetown University Medical Center.

I was aware that he performs reconstructive as well as cosmetic surgery and, until recently, did only one facelift a week, but I was impressed by the almost universal admiration I encountered for the beauty of his work and the inconspicuousness of his scars. I liked the fact that he worked a lot on men—whose scars are harder to hide—and when I had interviewed him for another article, I'd liked his manner. Some women may prefer the I'm-gonna-make-you-gorgeous approach, but I liked his clinical explanation of the work, his realistic emphasis on the risks, and the fact that he seemed to take the cutting of someone's face as seriously as the face's owner did.

Just one week after surgery, with the help of make-up to hide the bruising, this 60-year-old woman shows off the results of a face- and neck-lift, including lifting of her upper and lower eyelids, lips, and the corners of her mouth.

After a week of checking and thinking, I phoned for my first appointment.

Dr. Little examined me with the analytical eye of a very good chef examining a pound of tripe.

"Typical for your age," he said of the bag here, the droop there. Gravity had done its work everywhere except on my eyebrows, which hadn't fallen. ("It's because I'm always being surprised," I ventured.) The superfluous flesh beneath the chin was partially muscle, he explained—not handy muscle of the type needed for checking the top grocery shelf or examining a run in your hose, but like the muscle under the skin of a horse that helps it flick off flies.

He showed me roughly where the scars would run: from somewhere near the middle of the top of my head, about an inch back from the hairline, down to the front of the ear, behind the tragus—the little cartilaginous projection in front of the ear's entrance—then around and behind my ear and into my hairline.

As I listened, it became clear—clearer than *The Face Book* had made it—that what we were talking about here was, essentially, cutting my face off and sewing it on again. It would be much like tightening the upholstery on a sofa, with the same basic challenge: what to do with the excess fabric when you've stretched it over the frame. On a sofa, it ends up down in a crack at the back. On your face, it ends up discarded from somewhere behind your ears.

"You won't be able to wear your hair in an extreme upsweep," he said. "You'll have to have a soft droop at the back."

He asked me to move my eyes up and down to judge how much superfluous flesh was dangling over each. He intended only, he said, to work on the upper lids this time. Although things were pretty crinkly around the lower, he explained that the lift would alter the area under the eyes. Later, if I so decided, I could have the lowers done, too.

"Your eyes may have a faintly Oriental look for a time after the lift," he warned. "It's not an unattractive look on a woman."

At one point he said, "I give a very aggressive lift, but one that never leaves you 'pulled' or 'surgical' or 'unnatural'. It's the only way to a long-lived result." I felt a quick thrill of fear.

I was pleased with the doctor, and reassured by the layout of his office—even the arrangement of the magazines in the waiting rooms revealed a polished aesthetic sense. I like to think that somebody who's rearranging my face knows how to hang a painting.

He seemed pleased that I asked for no more than the adjustment of things that had sagged or sprouted around a face that I was basically comfortable with. "I won't work on someone who's essentially unhappy," he told me. "An unhappy person will not be turned into a happy one by plastic surgery."

In the cab home I reflected on his reminder that I was "one of the lucky ones." Indeed, in a world of tragic accidents, birth defects, murderous diseases, and hideous deformities, choosing simply to make oneself more attractive—when it's no longer necessary to lure the opposite sex into mating and perpetuating the species—is a luxury beyond price.

During the following week, I made an appointment for my second conference with Dr. Little, had my clinical "before" pictures taken (for use by him during surgery), and went to hairdresser Robin Weir for a pre-op perm and some moral rearmament.

Meanwhile, word had spread among my acquaintances. They began to ply me with tales of surgery gone awry: the tummy-tuck that had ruined the figure; the breast implant that gave four years of pain; the severed nerve.

My friend Maria Fisher, still pretty at 85,

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called me one morning to announce: "You can't have it. I've been lying awake all night thinking, and you just shouldn't do it."

When I turned up at the studio for *The Washingtonian's* "before" picture, the make-up man regaled me with horror stories of his own nose job—". . . almost drowned in my own blood. . . ."

Then I went in for the second conference—the one at which the plastic surgeon tells the patient what can go wrong.

I found myself watching his hands—broad, strong pianist's hands with long fingers—for the faintest sign of a tremor. When I dropped something and he politely stooped to pick it up, I raced him to the floor—not wanting those hands scrabbling on the carpet.

The litany of possible complications with a facelift was depressing, but Dr. Little laid them out as efficiently as a cat laying dead birds at a doorstep.

First, scars. He reiterated what I had read about different skins scarring differently, and added that, in about 10 percent of patients, thick scarring develops in the area behind the ear. It is possible to operate on these scars at a later date and refine them, he said.

Hematoma—severe bleeding that causes dangerous swelling and necessitates reoperating on the face—is the most feared possibility in facelifts. It is estimated to occur in between 2 and 8 percent of patients, generally within 6 to 24 hours of surgery.

I already had decided not to share this little conversation with my husband when Dr. Little mentioned the possibility of nerve damage. This can be either sensory—causing numbness—or motor, causing paralysis. (All patients have numbness in the cheeks after a facelift, but sensation generally returns in two to five months.) The greater auricular nerve, which runs up the cheek to the ear, is the one chiefly at risk. Paralysis of an eyebrow or a corner of the mouth can result. My husband's Phantom-of-the-Opera scenario danced before me.

A fourth risk is "sloughing," or tissue death, which can leave a gnarled, pink scar on the cheek or behind the ear; smokers, whose circulation to the skin is poor, are particularly at risk. Finally, as in all surgery, there is the risk of infection.

Dr. Little issued specific instructions aimed at keeping the risks to a minimum. My hair should be washed three times the night before surgery, using no conditioners or sprays; I was to take no aspirin or vitamins in the week before surgery. I was not to smoke. I was not to eat or drink after midnight before surgery. I must clean my teeth very well before coming in (I wouldn't be able to get a brush or floss in my mouth for a while). My recovery bed at home should be arranged so my upper body was at a 45-degree angle from the bed, to keep blood pressure down and help me avoid rolling over onto my new face.

It would not be a picnic. I would feel tightness in the neck area for two or three weeks after surgery; I could expect bloating, bruises, and a rather unattractive countenance for even longer.

Many plastic surgeons, he said, prefer that their patients recover at home rather than in a hospital. One seldom-mentioned reason is that hospital staffs tend to be less sympathetic to the patient whose surgery was motivated by vanity.

The author at home following her facelift. The swelling and numbness were so extensive that eating, talking, even reading were difficult.

"Stick to a soft and liquid diet for the first few days after surgery—yogurt, that sort of thing. No chewing allowed. Don't use straws, just cups and spoons. No stooping or exercises for a while." So far, so good. "And, of course, no talking or telephoning for a few days."

Two days after surgery, he said, I would have my drains removed. . . .

"Drains?"

I must have looked slightly sick. What would my husband make of drains?

Dr. Little gave my hand a professional, we're-in-this-together sort of squeeze on the way out. I smiled weakly, and hastened home to call my more supportive girlfriends for reinforcement.

"You're crazy," said the first one I reached.

The week before surgery was a blur of preparations for what I called Jowl Day. I stocked up on yogurt, bought two "bed wedges" to boost me to the 45-degree angle, and set up a sort of bed-cum-command-post in the middle of the up-

PHOTOGRAPH BY FIONA NEWELL

stairs sitting room.

J-Day dawned early after a sleepless, foodless, waterless night. Taking advantage of the time difference, I telephoned my mother in England, lest she call while I was incommunicado.

"I'm thinking of having a little plastic surgery," I said after a few pleasantries.

"You stupid woman!" she exploded. "You're making a terrible mistake." Later in the conversation, she mused, "You know, I've always thought if I only had my neck fixed. . . ."

I cabbed over to Georgetown Hospital, arriving before the appointed 6:30 AM, checked into Same-Day Surgery, and forked over a deposit of $2,000 to a surly young woman, whom I presumed to be in the ranks of the Disapprovers.

I was asked to remove my nail polish.

Then it was out of my clothes, into a hospital gown, and onto a gurney, to be trundled into a large sort of pre-surgery warehouse. I was given a couple of pills, then had time to gaze around at my fellow pre-ops, all laid out in the twilight like the parts-repositories in *Coma*. I signed a release that permitted grinning students to watch my face being peeled off and stitched on again, and allowed two touchingly young interns to attach me to an IV (dripping sucrose and antibiotics, they told me) and give me two of the nastiest shots in the bottom I have ever endured.

Dr. Little's resident came by to quiz me closely about smoking (apparently a lot of people lie, and then have big trouble on the operating table) and my surgical history.

Suddenly, as I lay there, I decided I did not want Oriental eyes—a desire I hissed urgently into the ear of the resident for fear of offending any Orientals in the vicinity; she promised to convey my wish to the doctor before he began tugging the corners of my eyes upward.

It was time to begin.

• 7:30 AM: I am trundled into an ice-cold operating room. After my blood pressure and pulse are taken the old-fashioned way, I am hooked up to a battery of monitors: a cardiogram; a blood-pressure cuff that tightens automatically every five minutes and reports its findings on a small screen; and a pulse oximeter, a device that attaches to a finger and, using lasers, reads the precise degree of oxygen saturation of the blood as it passes through the nail-bed.

"Some plastic surgeons operate in their offices," says Dr. Little. "I have no quarrel with that—but the patient should know whether the office is properly equipped. There is an accrediting program that checks the monitoring system in any office, along with emergency capabilities, CPR training, and so on. The question to ask is, 'Has the surgical

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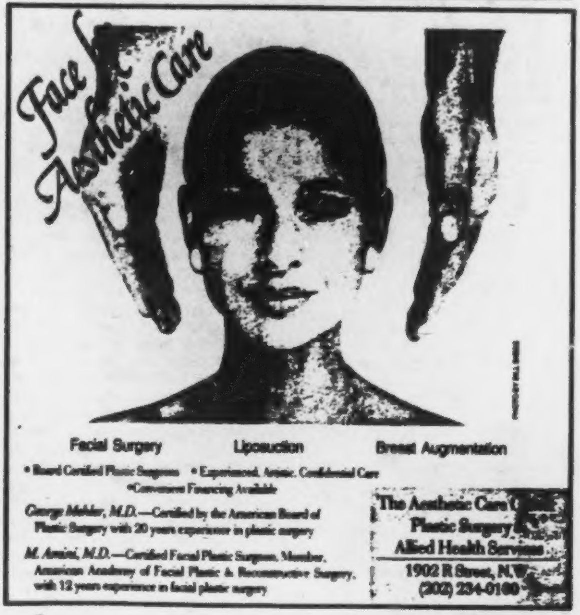

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facility been checked, and is it as safe as a hospital operating room?' "

• 8 AM: An electrical ground is taped to my thigh. A kind nurse covers my shivering form with a blanket. Somebody empties a hypodermic needle into my IV. There is a little light chatter with a nurse—and oblivion closes over my head like the waters of a warm pool.

The facelift alone, Dr. Little has told me, will take a full four hours—"and that's with fingers flying." The upper eyelids will be another hour.

• 8:05 AM: My hair—which Dr. Little had advised me to grow as long as possible before surgery—is parted and separated into clumps held together with rubber bands, Phyllis Diller-style. The areas of scalp slated to end up on the cutting-room floor are shaved—a strip behind each temple, a triangle above each ear, and a curved line along the hair's edge at the back of the neck.

• 8:10 AM: My face, already cleaner than ever, is washed yet again, with surgical soap. Surgical drapes are arranged around me, leaving only my face exposed. Beside the operating table, a rogues' gallery of my "before" shots—with my bags, droops, and dewlaps on vivid display—is taped to the IV pole. "Lying on your back, gravity disguises the very characteristics you want corrected," Little will point out as we reconstruct the surgery minute by minute later.

• 8:15 AM: Carefully, with one eye on the photographs and a special pen filled with surgical ink between his fingers, Dr. Little begins to sketch on my head the guidelines for the operation: first the scalpel lines up the side of my scalp for the facelift and across the upper eyelids for the second procedure; then, toward the middle of my face, the border lines up to which he believes he can safely "undermine" the skin—that is, detach it from the underlying tissues. This is where his remark about an "aggressive" facelift becomes manifest. Vertical lines about three inches apart on my forehead bracket a section of skin that will remain moored to the tissue beneath; the rest of my face, all the way into the nostrils and up to the very corners of the mouth, will be separated from its underpinnings.

"How deeply the undermining goes depends a great deal on the thickness of the skin and on factors that affect circulation, including whether or not we believe the patient who says she has given up smoking or takes no drugs," Little explains.

• 8:20 AM: Cotton pledgets are corked into my ears to absorb blood, and a seven-minute fusillade of long-acting local anesthetic is injected into my face. At this point the patient, who luckily remembers nothing of the unpleasantness later, winces frequently, and, if that be

Fountains of Youth

Retin-A, Collagen, and Other Treatments That Take the Years Off

There's more to aging skin than sagging and wrinkling. As some people grow older, they start to see dark circles under the eyes, brown spots on the face, rough patches of skin, and tiny blood vessels around the nose, chin, and cheeks. And as people age, their lips get thinner.

One of these problems—rough skin—sometimes has a very easy solution: using antibacterial soap. "A lot of women tend to think they don't want to use soap and water on the face," says Washington Hospital Center dermatologist Thomas Nigra. But they really should. If you clean your face with products other than soap, bacteria and parasites can grow rapidly, giving the skin a rough feeling.

Unsightly blood vessels can be cauterized using very fine electric needles, says DC dermatologist Glenn Fuchs. "We touch each and every little vein with a spark and it eradicates them—not completely, but about 80 percent of them. They gradually come back over time, but they can be done every year or two or three."

And brown spots can be removed by freezing, another simple procedure done in a dermatologist's office.

Ever since the discovery that it was effective against the fine lines associated with sun damage, Retin-A has been "the poor man's chemical peel," says Nigra. It eliminates fine wrinkles and imparts a healthy pink glow to the skin. There is evidence that it may help wrinkles that result from aging, not just from sun exposure. And, adds Fuchs, it sometimes smooths out blotchy skin.

Dark circles under the eyes were always thought to be a blood-vessel problem, something you couldn't do much about. But, says Nigra, Retin-A seems to help that, too. "People using Retin-A sometimes see marked improvement in that darkness under the eyes. It's the first thing I've ever known that helps."

During the first two to four weeks of using Retin-A, your skin may turn red and peel, and people with very sensitive skin may be unable to use it.

A tube of Retin-A, which lasts three or four months, is about $20 or $25.

Ortho, the company that makes Retin-A, is beginning a study this fall of a new retinoid that it claims is more effective and has fewer side effects.

Many of the patients of Bethesda dermatologist Leonard Cutler are on Retin-A to soften fine lines. Then they have collagen injections for the lines and wrinkles that Retin-A doesn't correct—the deeper, more furrowed spots above and between the eyebrows, and along the lines that run from the nose to the corners of the mouth. Collagen can be used to restore a more youthful contour to the lips and to fill out the vertical lines above them. The effects usually last six months to a year.

Collagen is more expensive than Retin-A—costing from $600 to $1,000—and sometimes requires several visits.

Collagen is a natural material (it comes from cows), and most allergic reactions are caught ahead of time.

Chemical peels—which involve painting acid on the skin to burn off the outer layer—sometimes work when Retin-A doesn't. They are somewhat painful and cost around $1,000. The resulting redness can last as long as three months, and six to nine months later the wrinkles begin to reappear.

The best protection from lines and wrinkles that result from sun damage is sunscreen. Several companies are coming out with broad-spectrum sunscreens that block out both the short UVB rays and the longer UVA rays, but they haven't been universally accepted.

"I am not in favor of this new sunscreen called Photoplex, which covers both UVA and UVB," says Nigra. "That means you get no pigment—and pigment is one of our best protectors from skin cancer." Because it doesn't stay on well and its sun-protection factor is less than fifteen, a lot of people get sunburned using Photoplex, he adds.

Nigra says that the best sunscreens now being developed are ones that stimulate the production of natural pigment while still blocking some of the sun's rays. Nigra, who sports a healthy tan, never goes outside without wearing Bergasol, a sunscreen still available only in Europe. It brings out the skin's natural pigment, with less sun exposure than usually required.

"There's never going to be a perfect way of getting pigment without sun damage," he says. "The whole trick is how you get the pigment and how little damage you do to achieve it. That's where our areas of research are."

—Marilyn Dickey

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her disposition, paints the operating room blue with four-letter words. Within moments she retreats into slumber, often punctuated by cartoon-quality snores. Dr. Little, perched on his operating stool over my recumbent form like a man approaching a tough steak dinner, begins to wield the knife.

• 8:30 AM: The first incision is a neat 1¼-inch cut perhaps an inch behind the chin. "That incision is absolutely vital for a 1980s facelift—which is not merely a tightening of the skin, but a structural reshaping," says Little. Inserting his knife into the buttonhole, he undermines the fat deposit there, freeing the skin and the all-important platysma muscle (about which more later) from all but a small amount of fat, which must remain to avoid the garroted look of lesser facelifts. Briskly, he scissors off the fat.

• 8:40 AM: Turning my head to the side, he begins his carefully charted incursion into the right side of my face. At this point, I surface like a seal from the dark pool of oblivion and observe, "Oh, so that's where you cut it." "Give her another 2.5 ccs," says a voice softly, and I slide back, reluctantly, as the knife continues its course. He slices an inch behind my hairline at the sides, with an inch-long perpendicular digression at the sideburn, then down the front of the ear and back behind the tragus. Then he loops back under the ear lobe, two-thirds of the way up the back of the ear, then straight across into the hair and back down along the hairline to the base of the skull, leaving perhaps two inches uncut at the nape of the neck. It is a long cut, but it is almost entirely concealed in the hair.

• 9 AM: "Once the skin is freed up, I can turn back the face and look at the muscle and tissue underneath," says Little. "This is where I can really see how deeply I can undermine."

• 9:15 AM: Taking pen in hand again, he sketches on the skin the line of the jaw as it will appear after surgery. Now he can begin sculpting in earnest.

"I work in bas-relief, creating a good line. This is where I really concentrate on the neck. I look at the naked muscle and, in most patients, discard much of it—in particular the vertical platysma, which serves no useful purpose. I retain the part of the muscle that runs under the chin. Working through that little peephole under the chin, which is held open for me by a resident, I tighten and stitch that muscle under appropriate tension, so that it works to support the jawline as a sort of internal chin strap."

• 9:30 AM: The arduous process of stanching the bleeding begins. "Plastic surgery is nothing but a battle between beauty and blood supply," Little quotes Sir Harold Gillies, the New Zealand-born father of modern plastic surgery. "Stopping the bleeding takes longer than any part of the surgery."

Hematoma—the specter that stalks both doctor and patient in any facelift—must be blocked at every possible point. Using the electrical cauterizer that was grounded on my thigh before surgery, Dr. Little zaps each tiny blood vessel as it presents itself, taking great care lest an indiscriminate move damage a nerve.

In a full lift, your face is essentially cut off and sewn back on, minus the excess skin and fat. The dotted lines show approximately where the main incisions were made.

As soon as the sculpting is complete on one side, he sculpts a matching bas-relief on the other.

• 10:30 AM: Now the only liposuction Dr. Little ordinarily uses in facial plastic surgery comes into play. Inserting the suction nozzle through the side of the face, he sucks from the side of the nose the pads of fat that define the naso-labial fold—the "smile-line" that creases the cheek and then droops into the dewlap of even the happiest senior.

• 10:35 AM: It is time to redrape the right side of my face. Freed from its mooring, shorn of its fat, cleft from its superfluous tissue, it can be tightened and sewn into a pleasing, more youthful configuration. First, Little pulls the skin tight above the brow and temple. "Little subtle things make a difference here. They can alter the expression and overall look," he says.

• 10:40 AM: He trims the excess skin from the scalp and with stout, fishing-line strength stitches, closes the wound. "The skin here is anchored to deep tissue, as it is behind the ear. To simply anchor it to the scalp would mean it would pull adrift." As soon as that is done, it is time to trim, anchor, and stitch the newly slenderized, de-bagged, smoothly muscled neck, trimming off the superfluous skin and neatly matching its edge to that of the cut along the lower hairline. Again, because of the stress, substantial stitches and stout thread are used. Finally, the side of the face itself is redraped and trimmed and tailored to the artful scarline that runs behind the tragus. While he's at it, Little inserts the tubular drains that run from the deeply undermined area at the corner of the mouth through the top of the scalp.

"It's invevitable that a certain amount of blood builds up there, but the drains keep it at a minimum," he explains.

The right side of the face is now completely closed up—and the entire process is repeated, in mirror image, on the left.

• 11:45 AM: The useful little incision under the chin is sutured shut. Both cheek drains are attached to a suction device. A heavy bandage dressing, completely concealing the past four hours' work and applying what Little calls "mild compression" to the whole, is wrapped mummy-style around my head, leaving only the center of the face free. The facelift is over.

• Noon: Rubber sheeting is laid over my clean bandages to protect them from any fallout. Dr. Little changes his gloves for the next quadrille on the program—the upper-eyelid surgery.

Fresh anesthetic is injected around my eyes. Examining the droopy-eyed "before" shots taped to the IV pole, Little slices an ellipse of skin—¾ of an inch by 1½ inches—from the right upper lid. He scoops out the fat from above the eye and from the inner corner of the eyelid. "Removing the fat from the inner corner creates a nice sweeping line across the lid," he explains. Carefully, he removes a section of the orbicularis muscle.

• 12:10 PM: He zaps the blood vessels with the cauterizer to block bleeding, then sews a delicate line of fine, even silk stitches—they look like the work of a French nun—along the top. He moves on to the left eye and gives it the same treatment. This is precision work: Sloppily executed, the lids can be left uneven; worse, vision can be impaired or even destroyed.

• 12:40 PM: Both eyes are washed dressed with antibacterial ointment, and wrapped. I am taken to the recovery room where, after an hour, the eyes will be unwrapped and ice-water pledgets will be applied every hour.

The surgery is over.

My husband is to pick me up late in the afternoon. Unwilling to jolt through traffic alone with a bandaged zombie on hi·

Everybody's Doing It

More and More People Are Surgically Turning Back the Clock. Here Are Reasons Why.

Carol Austin before—and five years and several operations after. The changes are subtle, but include cheek implants, lifting of the brows and corners of the mouth, and fat suctioning from under the chin.

Just a little fat off her hips and thighs would be nice, thought Carol Austin. From her knees and stomach, too. And around her eyes. And why not straighten her nose, and lift her brows, cheek[illegible]s, and the corners of her mouth?

Twelve operations later, the 45-year-old McLean resident is a walking testimonial for plastic surgeon Dr. Harvey Austin—her husband.

Austin isn't a typical plastic-surgery patient, but she does represent two trends: an increase in the number of people turning to cosmetic procedures and their greater willingness to talk—even boast—about their nips and tucks.

Our grandmothers didn't admit to dyeing their hair, let alone lifting their faces. Our grandfathers didn't even consider cosmetic surgery.

Now their offspring trade names of plastic surgeons. And in New York City, they describe it to chic *Details* magazine for the "Knifestyles of the Rich and Famous" column.

Estimates are that some 1.5 million cosmetic surgeries were performed last year. Safer techniques and affordable payment plans are two reasons for the increase. Another is the new eagerness among celebrities to open up their lives—including their surgeries—for discussion, which encourages others.

"Maybe a critical mass has been reached," says psychiatrist Dr. Michael Pertschuk, a consultant at the University of Pennsylvania's Center for Human Appearance. "Enough people have had surgery that almost everyone knows someone who's had surgery. It becomes a status symbol in certain circles."

Cosmetic surgery is being embraced by the same baby-boomers who have spent the 1980s jogging and watching their cholesterol. "American society is on a health kick," says Dr. Jeffrey N. Hausfeld, chairman of the division of facial, plastic, and reconstructive surgery at the Washington Hospital Center and author of *The Teen Face Book*. "We want to be fit and trim, have straight teeth and nice clothing. This is just part of looking our best."

Nowhere is this desire more evident than in the growing number of men turning to a quick fix for sags and wrinkles.

Hausfeld says looking better means taking years off but looking natural. "So people say to you, 'You look good. Did you get your hair done?' "

Surgeons find that patients now are more realistic; they don't want to look perfect, or like someone else. People most likely to be happy with the results are those who want to change a specific feature, not their whole life. Some are prompted to undergo surgery after a divorce or a significant birthday. But good surgeons often turn away people who hope that surgery will earn them a promotion or save their marriage. "There is a difference between using cosmetic surgery as a crutch—having unreasonable expectations—and using it to help you through a transition in your life," writes Dr. Elizabeth Morgan in *The Complete Book of Cosmetic Surgery*.

Good doctors screen for patients being pushed into surgery by a parent or a spouse, those who are clinically depressed, and those with a dysmorphic disorder—a condition in which they are obsessed with one part of their body.

Most patients have a healthy reason for choosing surgery: When they look in the mirror, they see someone who looks older than they do in their mind's eye. "People's mental image of their physical selves changes a lot slower than physical reality," says Pertschuk. "These procedures can bring in line the image of how people think they look."

Is this concern with appearance healthy? "To write off the desire to look better as pure vanity is not appropriate," says Rockville's Dr. Ronald Cameron. "After all, not caring about your appearance is one symptom of mental illness."

—Sherri Dalphonse

hands, he has rented a limo and recruited a male friend (his cutest, to my horror) to pick up his mate. I had expected to be groggy, almost comatose. Instead, I reel out of the recovery room like a truculent drunk, grumbling about the battleship-length of the limo and my husband's helpful gestures. ("What are you trying to do, kill me?")

At home, I examine the spectacle that presents itself in the mirror: In the middle of a helmet of bandages is a blue-inked face dominated by eyes swollen like a pair of Grade A Extra Large eggs, topped by a row of tidy stitches. A sinister-looking tube emerges from the bandages to a sort of vacuum pump attached to my waist.

I make my way upstairs to my little bed. (It's best to sleep alone during recovery, as even a friendly elbow becomes an object of dread.)

My husband has had my three prescriptions filled—for Cephalexin, an industrial-strength antibiotic; Percocet, a painkiller; and Ilotycin, an ointment for the eye incisions—and I have assembled all the other necessities.

Along with my two bed wedges, one atop the other, and supplementary down pillows, I require: a large supply of eye pads for applying ice water to eyes and witch hazel to other parts; a gel ice pack; hydrogen peroxide, Listerine, and dental rinse for oral hygiene (breath mints are a good idea, too); Erace, for camouflaging black eyes; moisturizing emulsion to grease up tightly stretched skin; Milk of Magnesia, to solve a problem associated with use of painkillers; and a large hand mirror for inspecting my face's ever-changing landscape.

Facelift recovery, a wise friend has told me, is an ideal time to drop a few pounds. For one thing, you're not hungry. For another, all you can squeeze into the odd hole in your face is liquids, custards, and yogurts—the latter a must for keeping your intestinal flora in fighting form against the depredations of antibiotics. A blender is a handy ally when yogurt becomes unbearable.

The rules for the first couple of days: No talking, no stooping, no excitement to raise blood pressure. All are pretty easy to follow except the talking part, which I resolve with a special Cagney-esque delivery.

I spend the day after surgery in bed, my eyes—too swollen for reading or television—only up to an occasional squint in the hand mirror to see what else could possibly swell. My husband kindly empties my blood drain, a task he was instructed in when he came to pick me up. He is a peach.

Next morning, after I take a cautious bath, he squires me back to the doctor's

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office for removal of the drain and some of the dressings. My eyes are like oranges—far too swollen to take out stitches. Back in my bed, looking like Sister Masocha of the House of Perpetual Pain in my wimple of bandages, I fiddle with the hair now sticking out from the top. To my horror, a hunk comes off in my hand. That night, the salivary glands in my neck, startled at their new location, begin to pump so hard I think I am drowning.

The next day Kitty, Dr. Little's nurse, carefully plucks the stitches from around my eyes. I note in my diary: "Eyes so swollen they'll look like empty knockwurst casings by the time they go down. Sides of nose pulled out like Lee Marvin's by all the swelling—is this permanent? Weird little bulges and bruises around mouth corners."

When my daughter visits on the weekend, she asks what has happened to my lower lip. Indeed, it has vanished—pulled taut by swellings on either side. "Maybe you can have some collagen pumped in," she suggests, "like Barbara Hershey."

The fact is, in having a facelift, you are choosing to surrender your good health and well-being for as much as a month. Having done so, I have decided to put my time away from the bustle of everyday life to good use. The first week, for example, is an ideal time to lose weight, grow fingernails, cook and freeze homemade soup, shop from catalogs, remove the dead from my Rolodex, write letters, keep a journal, have very close friends over, and meditate on a New Image.

By Day 6, it is time to have the final bandages and all but the heavy-duty stitches removed. Kitty sits me on an examination table, unswathes the mummy, and, puffing out her cheeks in concentration, carefully picks and snips at my scalp and down behind my ears. Then she leaves me alone to await Dr. Little's inspection. Gazing wildly around, I see a door leading off the examination room. Surely it is a john—and surely it has a mirror. I bolt from my perch, race in, and gasp at the monster in the mirror.

There is a mat of wild, stained hair, a face puffed like a soccer ball and dappled with multicolored bruises. But there, beneath it all, is the prettiest neck and jawline I have ever seen—defined, high, smooth, rounded, *mine*. I feel I will burst with elation. When Dr. Little bustles in to inspect his creature, its technicolor face is grinning like a jack-o'-lantern.

He examines its edges for signs of decay; he checks my incisions to see how they are scarring; he complains about my swelling—I apologize abjectly—and he leaves.

Husband Dick is waiting for me. Outside, it is a glorious day. We walk through the Georgetown University campus, full of beautiful young students with jawlines just like mine—although at the moment I look like a Ninja mutant Iranian terrorist swathed in all-black, a babushka, and sunglasses. We make our way to Paolo's on Wisconsin Avenue. I am giddy with joy. Dick is relieved, liberated, light-hearted.

Free at last from my diet of mush and enforced abstinence, I order wildly: the saltimbocca and wine. As we sit enjoying ourselves, with occasional friends waving or coming over to peek at my bruises, it becomes clear that I have made a mistake. My face is slowly inflating like a big balloon. My cheeks are melons. The salt is at work. Rushing home and into bed, I guzzle every diuretic I can think of, soak a tea towel in witch hazel, and lie moaning with it over my face.

Later, I wash my hair in the bath. Another downer. The dried blood and clumps of hair that detach themselves from the tangle are sobering in the extreme. It is only then, leaning cautiously to scoop hair from the drain, that the terrible truth dawns: A facelift means more face, less scalp. There's no such thing as a free lunch.

The second week after a facelift is good for organizing closets and bookshelves (still no heavy stooping), cleaning out purses, having lunches with good friends in small restaurants or at home, having friends drop by, and reading the books you've been neglecting. It's not a glamorous time. My diary reports: "Feel as though whole face is wearing a condom. Cheeks numb. Neck feels as though I'm being throttled."

When I answer the door to a messenger, he lets out a squeal of horror. In the mirror, I see why: The raccoon-eyed creature in the glass looks like a mugging victim. I feel like Quasimodo, Boo Radley, Mrs. Rochester—unfit for human society, yet quietly going stir crazy.

Out in the real world, the weather is exquisite. Dick and I decide to walk over and have a bite at Tunnicliff's outdoor café. With lavish applications of Erace, sunglasses, and a sort of burnoose, I look merely bizarre. My meal is simple—and saltless. We've turned down an invitation to dine aboard Malcolm Forbes's yacht that evening, but out in the sunshine, with nobody staring at old melon-face, we decide, hell, let's go.

By 6:30 we are being piped aboard, my visage hidden by a huge hat and scarf. Then something astonishing happens. Half a dozen women walk up and tell me about their experiences under the knife. A former White House social secretary had been "done" five years before. A writer, two years ago. A former

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Cabinet wife, twenty years ago.

"To me, it's like getting my teeth fixed," says an ex-protocol chief. A 30-year-old *Washington Post* reporter confides that her mother's recent facelift disturbed her so deeply that she is writing about her pain for another magazine.

This problem has not occurred to me. Reapplying a layer of Erace in Malcolm's gold-and-marble bathroom, I look at my face and wonder if my daughter is really upset about it. Perhaps it is a sort of generational betrayal?

I gloomily down a third glass of wine with dinner.

When I awake at 4:30 AM, Cinderella's head has turned into a pumpkin. I decide to lie low for a bit.

A few days later, Bill, an old family friend, drops by to pick up my husband for a boys' night out. At this stage, my face is still swollen and bruised, but in an interesting, bee-stung sort of way, like a battered Playboy bunny's. I answer the door, acutely self-conscious.

"Jesus," says Bill. "You're 28. A Sex Object."

After the guys leave, I warm up some leftovers, pour myself a glass of Bordeaux, light a dozen candles, and sit at the head of my dining-room table listening to some Rachmaninoff and meditating on the *Picture of Dorian Gray* and the scene in *Man and Superman* where Donna Anna, in hell, discovers that she can be any age she likes.

In the midst of my reverie I get a call from Louise, a hard-working, deeply religious woman who has cleaned for me since we were both in our early twenties. She works five days a week for the government, one for me, and one for her church. She can't come tomorrow, she says, but her daughter will. I ask how she is.

"Oh, fine," she says. "A little tired. But better days are coming."

Going back to my candles and wine and pretty china, I think about my own good fortune compared to Louise's struggles, with her grandchildren growing up among drug hoodlums, her endless toil, endless prayers, endless bus rides.

Tears begin to trickle down my swollen sex-object cheeks. I try to phone my best friend from adolescence, who now lives in New Jersey, for expiation, but she isn't home.

I blow out my candles and wash my dishes by hand. Later, talking to friends who have had facelifts, I find that the wave of gloomy guilt that engulfs me that evening is almost universal.

Two weeks after surgery, I return to Georgetown to have the heavy-duty stitches that underpin my new neck taken out. The bee-stung look has subsided, but there are still strange swellings, bruises, and bumps. The general configuration of my face and chin is pleasing, and I am pleased. Kitty, as she extracts the jumbo stitches, looks pleased, too.

Dr. Little gives me a lecture on protecting my investment—advice that any woman, facelift or not, might want to consider. First, he says, no sun at all without a heavy sunscreen of at least 25. No "facial exercises." Proponents claim that they build underlying facial muscles; actually they just stretch your face unnecessarily, encouraging more wrinkles. Facial massages, beloved of so many, do the same thing. And finally, he urges, make gravity your friend and not your enemy—sleep on your back.

I ask about the swollen areas beside my mouth, which feel as though there are beanbags under the skin.

"They'll disapper in a few weeks," he says. "That's what the blood drains were there to minimize. If they don't go, I'll give them a shot of steroids and they will."

As the third week dawns, I keep putting on the Erace and trip timidly into the *Washingtonian* office. My face is pasty and bloated, but everyone says they're pleased. I eat lunch with a friend and then head for the pool to swim for 30 minutes—my first exercise since the surgery. My weird face, smothered in 34 sunblock, swells even more in the cool water. My ears, with their stitching behind the tragus, seem to get water-logged faster; during my backstroke, my neck feels as though it's being keelhauled with a noose.

But sitting in the shade afterwards, I feel the joy and energy of a rapidly healing animal.

During the third week, I work at home and lunch with girlfriends. All are fascinated by my strange, bulbous face and slender neck, all curious about the price,

A Reason to Smile

Cosmetic Dentistry Offers Whiter, Smoother Teeth in Less Time With Less Pain

Some of the most exciting developments in cosmetic improvement have been in dentistry: Dentists say that more progress has been made in the past five years than in the last fifty.

Unlike a lot of other cosmetic work, most of these dental procedures take only a few appointments, and involve little or no pain.

In **bonding**, layers of tooth-colored plastic, called composite resin, are applied to teeth to hide discoloration, chips, cracks, and gaps. Teeth can be "resculpted" to produce an even smile. Bonding costs about $150 to $300 per tooth. The main drawback: Teeth look good only for three to eight years before they begin to wear, discolor, and chip.

A variation on bonding, **laminate veneers** are thin, tooth-shaped porcelain shells prefabricated in the laboratory and bonded to teeth, somewhat like attaching false fingernails. Veneers cost more than bonding. But, says Dr. Nancy G. O'Donoghue, director of Washington Cosmetic Dentistry Associates, veneers last ten to fifteen years and the porcelain does not stain.

If the problem is silver fillings that have turned black, **porcelain inlays** can be placed on the surface of back teeth to hide the discoloration.

Crowns—custom-made caps that cover the whole tooth—are used less these days for cosmetic purposes. Crowns are used on severely fractured teeth and on back teeth, where bonding may not be strong enough. Although they last up to twenty years, crowns are costly—$350 to $600 a tooth.

In **bleaching**, up to twelve teeth at a time are isolated with rubber (because bleach hurts gums) and treated with a bleach solution for up to 40 minutes. When done properly, bleaching doesn't harm teeth and isn't painful. Usually three to four treatments may be required, at about $75 to $250 per visit. Stains do not always come out; bleaching is successful 75 percent of the time.

Cosmetic contouring is a process in which teeth are reshaped with a rotary instrument. In just a few minutes, and for comparatively little money ($50 to $200), "fangs" can be recontoured, irregular edges smoothed.

Orthodontists estimate that some 30 percent of their patients are adults, largely due to less visible **braces**. They can be made of clear plastic or ceramic—an almost undetectable, tooth-colored material. New "invisible" braces are even more discreet: The brackets attach to the backs of teeth and pull, rather than push, teeth into position. But they are more complicated for doctors to put on, and not everyone can wear them. —ADAM A. DOBRIN the scars, and the pain.

"There is no pain," I say. "Only the pain in the neck from losing a month of your life, and not knowing from day to day which fruit you're going to look like."

There are setbacks. One day I awake looking like the eggplant that looks like Richard Nixon; I cancel three social engagements. Twice I wake exhausted after nightmares that feature strangling or choking, or that the operation was a failure and I am a hideous monster. One day I am so exhausted that I just take to my bed. The next, I decide to go swimming anyway and return tired, lumpy, and choked by my neck muscle.

The black eyes feel as though they'll never go away, my scalp as though it will never heal. My husband says I look terrific but informs me (we are back in the same bed now) that, sleeping on my back, I have begun to snore like a trombone.

Sex object, indeed.

Finally, at the beginning of the fifth week, I go for a solemn confabulation with Robin, the hairdresser. He, I know, is well versed in the mysteries of coifing the lifted. He has confided long ago that the real reason for the "VIP Room" is to allow the juggling of coiffures after plastic surgery in a discreet setting where his clients' scars can remain veiled from prying eyes and vulgar gossip.

He ushers me into his shrine to born-again beauty. With the right degree of reverence, Robin approaches the still-lumpy but jowl-free butterfly that is emerging from its chrysalis. This is a moment of truth. Every woman knows that a lousy haircut means a lousy month—and how much more crucial is the cut that is to showcase the rejuvenated face, yet conceal any lingering scars.

"Don't let's think 50-year-old Washington matron," I beg. "Or even 40-year-old Englishwoman. We're going for 30 and French."

The cut is superb: a splendid curved crown, wisps at the back of my neck covering the scars, hip-looking Shirley McLaine-style bangs and tendrils in front. With a swift, sure hand, he applies two shades of highlight—one lighter, one darker—on my mouse-brown hair to give it a touch of volume. A wash, a blow-dry, a brush, and I am complete.

The woman in the mirror is not a raving beauty; not a 30-year-old French sex symbol; not a girl strange men would jostle one another to woo at a party.

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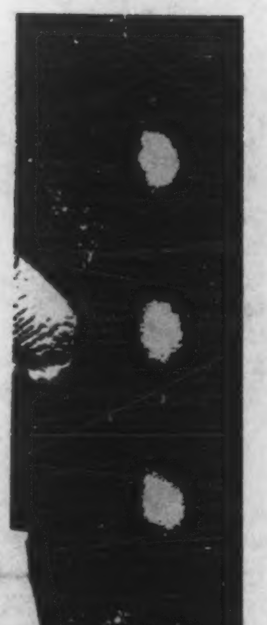
Young Again!

Thin Again

Liposuction Can Get Rid of Love Handles or Saddlebags—for a Price

By Salley Shannon



Mama always said you have to suffer to be beautiful, so when I first heard about liposuction—having those stubborn love handles or saddlebag thighs sucked away forever—I thought, sure, why not? Even though it's a medical procedure, and acquaintances who have had it done were bruised for weeks, I persisted in thinking of liposuction as one step beyond having your legs waxed.

Liposuction has been around since 1982, although a few doctors were using similar techniques before then. Last year, a quarter of a million people had some offending flab suctioned away—making liposuction the most popular cosmetic surgery in the United States. Although my family thought it was a crazy idea, I told my editors I was intrigued with having my body "sculpted." I said I'd research liposuction and then decide whether to undergo the procedure.

Well, after much research, my slightly Rubenesque thighs are perched firmly on the fence. What I found is this:

- Liposuction works, in most cases. Fat that is suctioned off stays off.
- It's safe when performed by a well-trained surgeon who has done the procedure many times.
- It's expensive. The most common liposuction—that of the thigh, buttocks, and tummy area—together averages between $3,000 and $5,000, plus any hospital costs.
- It's surgery. The ads you see with dramatic "before" and "after" pictures can obscure the fact that what goes on in between is serious stuff, with patients draped, anesthetized, intubated, and often catheterized and transfused.

It's that last point that stops me. I can't decide whether the after is worth the in-between.

One of the most difficult things about liposuction is choosing a doctor. Medical dogfights over who is "qualified" to perform the procedure have gone very public, leaving consumers confused about which doctors are likely to do a super job and which might suck out your vital organs by mistake. Even though the complication rate for liposuction is low, there have been eleven known deaths following the procedure. An alleged liposuction-related death in a Northern Virginia doctor's office is being investigated.

Liposuction is a lucrative business—overhead is low and the supply of aging baby-boomers is high. And the procedure is not all that difficult to learn if a doctor is already trained in another surgical specialty. Anyone with a medical license can legally perform liposuction. The problem is that physicians who don't have adequate training or experience are often unprepared for the complications that can arise—infections, skin sloughing, long-term numbness, and embolisms (loose pieces of fat that can get into the blobdstream and lodge in the heart, lungs, or brain).

"Even when potential patients try to be good medical consumers, they run into a stone wall erected by state and federal governments, medical societies, and individual doctors themselves," says Congressman Ron Wyden of Oregon, who chairs a House subcommittee now investigating cosmetic surgery and looking to regulate the industry. "It has become virtually impossible for patients to tell who is a good, qualified doctor and who is not."

Certification by a medical specialty board used to stand for something, but these days any

Liposuction is now the nation's most popular cosmetic procedure, because fat that's suctioned off stays off. Here, Chevy Chase plastic surgeon Csaba Magassy suctioned fat from this man's abdomen in his office operating room, one of the few in the area that are accredited.

Suctioning works best when you have localized areas of fat, like in the calves and ankles, and you are not generally overweight. This is an operation to lose inches, not pounds.

two or three doctors can form their own "medical board" and declare themselves "board certified." Although the American Medical Association recognizes only 23 specialty boards, more than 100 are incorporated, and it is difficult for consumers to know which is which—and whether, given all the medical mud-slinging going on—it's even worth it to find out.

While liposuction would seem at first glance to be the province of the plastic surgeon, it was invented by a French gynecologist. Gynecologists, otolaryngologists, plastic surgeons, and their bitter competitors, cosmetic surgeons—each specialty claims it is the best trained.

In the Washington area, most of the doctors performing liposuction are members of one or more of the following groups: the American Society of Plastic and Reconstructive Surgeons; the American Academy of Facial, Plastic, and Reconstructive Surgery; the American Academy of Cosmetic Surgery; the American Board of Otolaryngology; the American Society for Aesthetic Plastic Surgeons; or the several liposuction societies.

The American Academy of Cosmetic Surgeons is headed by Dr. Julius Newman of Philadelphia. Newman, who has a huge practice and drives a Rolls Royce with the license plate "Dr. Lipo," is considered the great "Satan" of the American medical establishment by plastic surgeons. Newman is largely responsible for challenging the claim that board-certified plastic surgeons are the best qualified in this field—arguing that cosmetic surgeons, who are certified in any of the other surgical specialties, are equally qualified. The fighting between organizations seems to have more to do with politics and money than competency of individual members.

While there are a few local doctors whose background and ethics seem sketchy, the great majority of surgeons contacted for this article think the doctors doing liposuction here are, in the main, well trained. All the doctors are quick to add, however, that before signing on you should ask questions about where the doctor learned liposuction, where he has hospital admitting privileges, and how often he has performed the surgery. (For more information on finding a doctor, see page 189.)

When you've found a doctor, you have to write a big check. Liposuction, also called suction-assisted lipectomy (literally "fat removal") can cost between $750 and $7,000, depending on the extent of the procedure, which doctor does the suctioning, and whether it's in his office or a hospital. If you want your waistline, thighs, and buttocks suctioned, a few local doctors charge about $2,500 for an in-office procedure, but the average rate is between $3,000 and $5,000. If the doctor operates in a hospital or ambulatory surgical center, that adds another $1,000 to $1,500.

Health insurance generally doesn't pay for purely cosmetic surgery, but check your policy anyway. Some insurance companies, though they won't pay the surgeon's fees, will cover laboratory or hospital costs.

Clearly, cost isn't stopping people, nor is the find-a-doctor problem. Among women, liposuction of the thighs, buttocks, and abdomen has surpassed breast augmentation and nose jobs. Fat can also be suctioned from arms, knees, calves, and ankles. Liposuction often is used as part of a full face- or chin-lift and sometimes is done instead of a facelift.

While more women than men have liposuction, men are increasingly turning to it to remove love handles or to correct a fat neck or jowl area. Liposuction is very successful in correcting gynecomastia, or feminine-looking breasts in men.

Local anesthesia is used in small surgeries, but general anesthesia is more common, even in office operating suites. The incision for the suction tube is only about an inch long—so it sometimes can be hidden in skin folds or hair. Several might have to be made in the same surgery. The surgeon plunges the pencil-thin, steel cannula up and down, breaking up the fat. At the same time, suction draws the fat cells out of the body and into a collection jar. (The liquidy mass is yellowish-white in color, with very little blood.) Although the area suctioned will be bruised and sore, the actual wound is tiny, sealed with a suture or two and covered with a small bandage.

The tissues immediately begin to swell when the fat is sucked out, so the surgeon must depend on experience to know how much fat to remove and how to balance both sides of the body. If your surgeon learned liposuction in a weekend course, you may not be satisfied with the results. One thigh might be bigger than the other, for example.

Ada*, a 52-year-old Virginia woman, had her buttocks and thighs suctioned six years ago, when liposuction was very new. One side is noticeably larger than the other, the cannula left ripple marks, and one buttock is permanently numb. "It was risky, having a new operation," she says. "I knew the risks. My doctor was very apologetic about the results, and offered to operate again, but I didn't go through with it."

Given the expense of liposuction and the fact that insurance usually doesn't cover it, you might expect that patients would be largely upper-class. But it isn't so. "Patients really cross the spectrum. They are mostly working people, men and women from their mid-thirties to mid-forties, but also in their fifties and sixties," says Dr. Diane L. Colgan, a plastic surgeon in Potomac. "Often they are people who have saved up for a long time to have something done about an area of their bodies that they've never liked."

Elizabeth, a 40-year-old Northwest DC woman, did just that. She went to Dr. Bahman "Buck" Teimourian, a Rockville plastic surgeon who was one of the first in the world to

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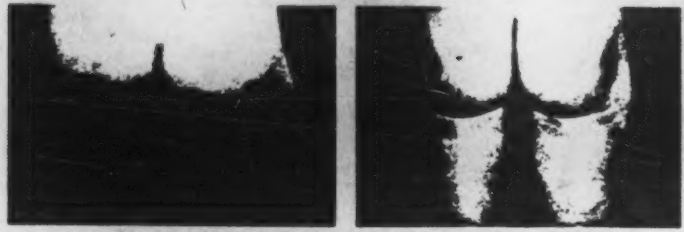
Washingtonian contributing editor Salley Shannon last wrote on weight loss in the March issue.

*Names of some patients have been changed to protect privacy.

[illegible]

Liposuction is very successful in correcting gynecomastia, or feminine-looking breasts in men. Other procedures popular with men are suctioning of love handles and jowls.



Liposuction of the buttocks is one of the most common operations women request. Suctioning can make you look better in jeans, but there can sometimes be creasing that looks unattractive when you're in a bathing suit or unclothed. And it does not get rid of cellulite.

perform liposuction. "I wanted to see if liposuction surgery could do anything about my heavy legs," Elizabeth said. "The rest of me is slender, but I've always had big legs and ankles. Very unattractive and out of proportion. I guess I inherited them. Someone made a remark about how ugly my legs were when I was in my early teens, and from that day on, I hated the way they looked." Elizabeth was so self-conscious about her legs that she often trimmed the bottom half of herself from photographs. "I know it's silly to be so vain; but we are, aren't we?" she says.

Three years ago, Dr. Teimourian operated. It took about six months for the real outcome to show—there's more bruising and swelling on liposuctioned extremities. The results pleased Elizabeth so much that she now wears shorts. "Now when I shop for shoes, I'm happy to stick my feet out," she says.

Most liposuction patients, like Elizabeth, are not really overweight. The first thing a doctor will tell you is that this operation is not the salvation of the obese. It isn't a substitute for losing 20 or 30 pounds. In fact, if you need to lose 20 pounds, some physicians might not take you on—although many might, if your weight has been stable and you make it clear that you just want to get rid of that tummy bulge or those fat knees.

"It isn't right to operate on heavy people, even if they're healthy," says Dr. Roger Anderson, a Rockville surgeon. "You can't safely remove all that much fat."

The removal of too much fat can lead to excessive fluid and blood loss, so doctors are increasingly limiting the amount they will suction in any one procedure. How much is taken? One woman who had a "moderate" amount of fat removed from her outer thighs and abdomen says she lost about a pound and a half—and wore slacks one size smaller, which was her goal. You lose inches with this operation, not pounds.

For that reason, liposuction can't work miracles—it won't make you look like Marilyn Monroe if you're built more like Roseanne Barr. "I can't tell you how many women come in here who are, say, size 6 or 8 on top and size 12 or 14 on the bottom," says Dr. Colgan. "Suctioning helps, but you can't make them match completely when they're that much out of balance."

Dr. Sharon Romm, who teaches plastic surgery on the medical faculty at Georgetown University, agrees. "I ask women, 'What do you want to look like?' and they often tell me, 'Just like you.' Well, I weigh 90 pounds, and the patient telling me this will weigh maybe 170 pounds. You can't make a big woman into a skinny chicken."

Still, it's easy to see why this operation has become so popular. Except for thin winners of the genetic sweepstakes, many of us have at least one little pocket of fat somewhere by the time we hit our thirties or forties. Family heredity determines where those places will be: If your mother and aunts all have violin-shaped "riding breeches" or "saddlebag" thighs, you probably will, too. Sometimes all the men in a family will have slack-looking, jowly chins

PHOTOGRAPHS COURTESY OF BAHMAN TEIMOURIAN M.D.

even in their teens and twenties.

And, as many of us know from experience, 100 sit-ups a day seldom make love handles, little rolls of fat above the waist, vanish. "A lot of the men I do liposuction on are runners and weight lifters who still have love handles despite their good condition," says Dr. Wesley Price, co-director of the Center for Facial Rehabilitation at Fairfax Hospital.

Before liposuction, you had to live with those pockets of fat, unless you wanted to undergo a massive surgical resection that left large scars. Because new fat cells don't form after adolescence, fat that is suctioned off really does vanish forever. Even if you do gain weight, you won't bulge the way you would have, because the fat cells that were removed aren't there to expend.

"The fat just never came back," says a Reston woman of the thigh bulges she had removed three years ago. She is less pleased with the suctioning of her buttocks done at the same time, mostly because of "cellulite," the textured fat many women have on their thighs and buttocks.

Liposuction does not correct cellulite. I first learned that over lunch in a fashionable New York restaurant. As I told a friend about this article, two young women at the next table halted their conversation to listen to ours. "Excuse me," one of them finally said, leaning over. "If you're going to write about liposuction, you have to tell people that it won't get rid of the cellulite on your thighs and bottom. I know, I had the operation."

"Rip-off!" her companion agreed. "I thought I would look better on the beach, but I look worse. My bottom is all rippled-looking."

I asked if the doctor hadn't warned her that results depend on skin tone. "Sure," she replied. "But who has good skin tone on her behind?"

Liposuction is most often performed on people approaching or in middle age. Generally, the younger someone is, the better their skin will tighten up after surgery. But some people in their sixties have excellent skin tone, and some people in their twenties don't. This, too, is at least partially a matter of heredity.

"The best candidate for liposuction is trim and healthy, with skin that is still elastic, who has one or a few localized areas of fatty tissue that just don't respond to any amount of dieting or exercise," says Dr. Ronald R. Cameron of Rockville. "It all depends on what you want. If you want to look better in tight jeans, the operation will help. If you have a lot of cellulite and want to look great in a bathing suit or short shorts, it won't. But I've done a number of women with very fatty thighs and a lot of cellulite who are very happy with the way they look after the operation."

That's another good thing about liposuction. The two New York women aside, a majority of patients seem happy—even overjoyed—with their results, although some wish they could have had just a bit more fat removed. A few do, by having the surgery again.

Doctors say the patients who are happiest with the results are the ones who clearly understood the tradeoffs involved. And there can be several. You may get flatter buttocks, but you'll get more of a crease where they meet the top of the legs. Rippled, saggy skin will, after the fat holding it up is removed, be even more crinkled. You will look much better in clothes, but you may avoid mirrors after a shower.

The smaller suction tubes that doctors now use leave less dimpling and rippling than the larger ones of a few years ago. The fat the doctor leaves behind really is "sculpted," and there is a certain amount of artistry involved, but "beware of the doctor who tells you he considers himself an artist," warns Dr. Lawrence O. McKnelly of Alexandria. "All of us in this business have a certain amount of arrogance, but that's carrying things a bit too far. I'd check the credentials of the 'artist' particularly well."

Whether you have the surgery in a hospital setting or the doctor's office will depend mostly on the doctor you select. A majority of doctors have in-office operating suites. Dr. Csaba L. Magassy and his partner Dr. Bernard S. Teunis, who both teach at area medical schools in addition to maintaining their practices, have an accredited operating room in their offices, which has much of the life-support equipment found in a hospital. "Having the surgery here offers flexible scheduling. There's less chance of infection than in a hospital. It also saves the patient money, because there aren't hospital and anesthesia bills coming in later," Dr. Magassy says.

Those Unsightly Veins

A New, Non-Surgical Treatment Makes Them Disappear

Until recently, people with small spider veins and the larger varicose veins usually faced surgical "vein stripping," a painful procedure that leaves scars, requires hospitalization, and costs thousands of dollars.

Dermatologists and vascular surgeons now have embraced a non-surgical treatment called sclerotherapy, which they say virtually eliminates these networks of blue veins.

Spider and varicose veins are vessels that become enlarged when their walls weaken, allowing blood to pool in them. Why this happens is not known, but in most cases heredity plays a part, according to Dr. David Green, director of the Varicose Vein Treatment Center in DC.

Sclerotherapy works by injecting the vein with a solution—usually saline—that irritates its inner lining, causing the vessel to shrivel and disappear. After the injection, the leg is wrapped in a tight compression bandage that is worn for several hours, or sometimes days.

Generally, patients can leave the physician's office immediately after treatment, which lasts about fifteen minutes. There is little pain—patients may feel a slight prick from the needle and a cramping sensation for up to a minute.

The veins disappear in several weeks or several months; the number of sessions depends on the extensiveness of the veins and their response to therapy. Each treatment costs $150 to $250.

While doctors say that sclerotherapy is the safest, most effective treatment available, it cannot guarantee 100 percent improvement. "Treating these veins doesn't exclude getting new ones," Green says. "But veins that are treated will never come back, and the difference between treated and untreated leg veins is like night and day."

Although doctors agree that removing spider veins does not harm circulation—blood is not flowing through these veins and the body has plenty of other veins—rare complications have occurred.

According to Dr. Mitchell Goldman, vice president of the North American Society of Phlebology (diseases of the veins), some solutions can cause skin rashes or slight leg discoloration.

"The problem is, a lot of doctors who have little or no training in phlebology or dermatology decided to perform sclerotherapy because they think it's easy, and in turn they pass the work off to nurses and medical techs. Patients should insist that the doctor perform all the work himself and that he is qualified," Goldman says.

—Adam A. Dobrin

A down side of office surgery suites, few of which are accredited, is that a lay person can't tell whether the enamel-and-chrome gadget in the corner is equipment that really could save his life. Another disadvantage is the lack of peer review. Hospitals check out doctors before allowing them to perform surgery there, and a panel reviews any surgical emergencies and disasters. In an office setting, there aren't such checks.

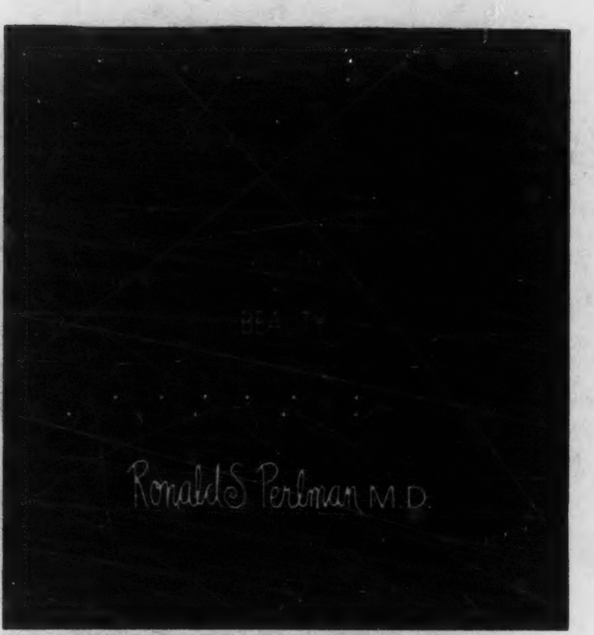
> **"I thought I would look better on the beach, but I look worse," says one liposuction patient. "My bottom is all rippled."**

Would-be patients should ask where a doctor has operating privileges. If he isn't on the staff of at least one major area hospital, consider that a red flag. It's one thing for a surgeon to have his own operating room if he has the option of using Georgetown or Fairfax or Providence Hospital. It's another if he uses his own operating room because he isn't allowed to operate anywhere else.

If a considerable amount of fat is to be suctioned, the doctor generally will ask you to put one or two pints of your own blood on deposit at a hospital blood bank, to be used during surgery. This costs about $70 per pint. Some doctors now routinely do such autologous transfusions in the belief that it speeds the recovery process.

The first three days after surgery, expect to feel as though you've been hit by a truck. Alicia, a patient of Dr. Wesley Price, had her inner and outer thighs and tummy bulge suctioned. "A nurse told me she had it done Wednesday and was back at work on Monday," Alicia recalls. "Well, I guess people's tolerance for pain varies, but I couldn't have gone to work the week after my surgery any more than I could have flown to the moon! You wake up in a long support girdle, which you keep on all the time. The first couple of days are very bad. There's a general ache. I walked very gingerly for two full weeks, and still was walking carefully when I went back to work after three weeks."

"There is considerable pain and soreness at first," says Dr. Talal Munasifi, head of plastic surgery at Arlington Hospital. "On the other hand, these are the only patients who come to the office two or three days after surgery with make-up on and their hair done. Liposuction does seem to make people happy."



BEAUTY

Ronald S. Perlman M.D.

UNDERSTANDING LIPOSUCTION

Diet and exercise can only do so much to improve your appearance. If you are unhappy with the way you look or want your clothes to fit better, you may be a candidate for liposuction. The best way to find out if you are a good candidate is an individual consultation with a qualified, experienced surgeon. In general, the best results are obtained in men and women who are:

- In good health with good skin tone.
- Have localized areas that don't respond to diet & exercise and are disproportionate to the rest of their bodies.
- Understand that this is not a weight loss mechanism.

BEFORE

AFTER

Questions you should ask:

What exactly is liposuction?
What areas can be improved?
Are men and women treated differently?
What about facial sculpturing?
How long is the recovery period?
Is there pain or scarring?
Are the results permanent?
Can it be repeated?
Will cellulite or uneven, wrinkly skin be a factor?
Where will the surgery be done?
What are the limitations of the procedure?
Are there possible complications?
What is the recovery time, and are there restrictions during the healing?

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Young Again!

A Whole New You

The Latest on Breast Enhancement, Hair Transplants, Nose Reshaping, and More

By Salley Shannon

While liposuction is the nation's most commonly performed cosmetic procedure—increasing from some 1,000 operations in 1981 to an estimated 250,000 last year—other cosmetic surgeries are also on the rise. According to the American Society of Plastic and Reconstructive Surgeons, between 1981 and 1988 there were 34 percent more nose jobs, 40 percent more eyelid surgeries, and 215 percent more tummy tucks.

After liposuction, the most popular surgeries are nose reshaping, breast augmentation, facelifts, eyelids, tummy tucks, breast reduction, chin implants, ear pinning, forehead lifts, and hair replacements.

Purely cosmetic procedures are generally not covered by insurance, but don't assume that it's the case: Check. A policy may cover anesthesia costs, operating-room fees, or some other portion of the total bill.

Recovery after any of these surgeries is affected by the sort of anesthesia used. All but the most major cosmetic procedures can be done using local anesthesia to numb the area plus sedation to make you sleepy and relaxed. If you and your surgeon think you can manage it, this should be your choice. Because general anesthesia knocks you out completely, it will make you feel exhausted longer, maybe for a month or more. All anesthesia carries some risk. Know what you will be getting, especially if you have any drug allergies.

Nose reshaping (rhinoplasty). You may remember the high school or college friend with a large or ethnic-looking nose who emerged after Christmas vacation sporting a new, turned-up version—modeled after Sandra Dee or Doris Day. The "nose of the decade" it was called.

It looked cute at age nineteen, but it looks odd on the mature face of a 40-year-old. Somehow, it doesn't move right when the wearer changes expression.

This is not the "nose job" of today. "If you can tell the nose has been 'done,' it's not a successful operation," says Dr. George Miller of Alexandria, who says this is his favorite operation—and that he hasn't done a turned-up nose in years. About a third of the nose operations he performs are to redo nose-of-the-decade noses. "Fortunately, there is no generic 'vanilla' nose anymore," he says.

"Often today, when a person comes in and wants a very large ethnic nose changed, he or she doesn't want to lose that ethnic identity. He just wants the nose to fit the face, to be in scale with the other features."

Because the goal is to balance features, not just to correct a large nose, surgeons often insert chin or cheek implants at the same time.

Rhinoplasty can reduce the overall size of a nose, reshape a tip, remove a hump, or correct the angle at which the nose joins the face. Sometimes it does all these things. It can be performed under local or general anesthesia and usually takes one to two hours.

The incision is usually made on the inside of the nose, through the nostrils, so there are no outside scars. Through the incision, the surgeon chisels, trims, and contours the nasal bones to reshape the bridge. Removing cartilage can reduce the tip or length of the nose.

Some people with a breathing problem caused by a deviated septum, or a misshaped inner nose, have the outside of the nose changed at the same time; they have the inside corrected. In such cases, insurance may cover part of the cost.

After surgery, the nose is usually packed and a splint of plastic or plaster is placed on it. The packs come out in a few days; some doctors don't use them at all. The splint is worn about two weeks.

The nose is quite swollen at first. It can take up to six months to a year for all swelling to subside—but it will look normal to everyone but its owner in about two weeks. At that point, bruising around the eyes may be all that gives away the fact that there has been an operation.

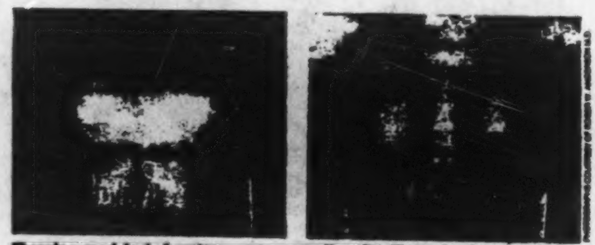
Too much activity in the early weeks and sometimes months—especially bending and lifting—can cause aching, swelling, or bleeding.

Cost: $2,500 to $4,500 for the surgeon's fee, plus $800 to $1,500 if an ambulatory center or a hospital is used instead of an office operating suite.

Breast augmentation. There are a lot of women in America who have wished for "a little more," and last year 75,000 of them got it.

But here's another statistic: One out of every ten women will develop breast cancer. The biggest question researchers are trying to address: Does having a breast implant worsen those odds?

"In all the thousands of breast cancers I've seen, I've never seen one that I could link in any way to a breast im-



There's a good deal of controversy surrounding the silicone implants used in breast augmentation. Though they don't seem to cause cancer, they may make it more difficult to detect.

ion," says Dr. Leonard M. Glassman, radiologist at the Betty Ford Comprehensive Breast Center at the Columbia Hospital for Women in DC. He doesn't think implants cause cancer.

Nor, he says, do implants mean that cancer can't be detected. "Having an implant makes getting a mammogram a little more complicated," Glassman says. "You can't do just the normal views of the breast; you have to do some special shots developed for women with implants. But the end result is that the ability of the mammogram is not compromised, if the prosthesis remains able."

Glassman does suggest that women ask their surgeons about placing the implant behind the muscle wall, not between existing breast tissue and the muscle. Although a more complicated procedure, it allows for better mammograms because all the tissue can be seen.

Glassman's reassurances aside, most doctors discourage women with a strong family history of breast cancer from having the surgery. Studies last year found that women with implants who develop breast cancer tend to have a worse prognosis, possibly because the cancer is detected at a later stage. No one really knows the long-term effect of living with an implant 40 or more years.

Doctors also discourage women who want to breast-feed from getting implants. They can still do it, but there's an increased chance of breast infections.

Breast implants are typically oval-shaped silicon balls placed inside a silicon envelope. One type, called a "fuzzy implant," is further coated with polyurethane, which encourages the breast tissue to grow into them. This kind of insert reduces the incidence of capsular contracture, a common complication in which the body tries to reject the foreign object. The result is hard, orange-shaped breasts that don't look or feel natural—and can't be manipulated enough to get a good mammogram. Up to 30 percent of women who have the standard silicon-filled implants develop this problem. The contracture can be corrected, but it generally comes back. Women have to decide whether to live with it or have the implants taken out.

While the use of fuzzy implants cuts down the rate of capsular contracture, some women still have the problem—and taking out the implant once tissue has grown into it can be a tough job. These implants are also more expensive.

How much "more" do women usually want? Doctors often let you try out different sizes of implants by putting them in your bra. Some surgeons make the decision for you; they only stock implants in the "medium" size range. Lorelei Lie, a representative of Surgitek, which makes breast implants, says that the sizes she most often sells to local doctors are between 220 and 300 ccs. The 220 size is a good B cup, and the 300 is a full C. But the size a woman is after the operation depends on how much breast tissue she had before augmentation. Implant sizes go all the way up to 800 ccs, but the very large sizes are generally used in breast reconstruction following cancer surgery.

"On the West Coast and in Texas, women opt for bigger implants," says Lie: "Locally, there is a definite trend toward bigger implants than those most often used a few years ago. And if you talk to women who have had this operation, a lot of them say their only regret is that they didn't go for a larger size."

Choice of implant size is constrained by how much the skin will stretch. If a woman is really flat, she probably can't go to a D cup. But if she's really determined to, she could have an intermediate operation, say to size B, allow the skin to stretch, then have surgery again for the bigger size. But doctors report that hardly anyone here does that—professional women don't want the bustiest sizes.

The most common incision site is in the fold where the breast meets the chest wall, although an incision around the nipple or in the armpit is sometimes used. The incision is only about two inches long. The operation can be done under local or general anesthesia, typically takes from one to two hours, and is almost always done on an outpatient basis. The breasts are sore for a few days and swollen for about two weeks.

Many women find that they don't have to miss more than a couple of days of work, although they have to avoid strenuous movement for several weeks.

Cost: approximately $3,000, plus any hospital and anesthesia charges.

Breast reduction. More than 30,000 American women had this surgery last year. Very large, heavy breasts not only can cause serious back problems, but mean a woman has trouble finding clothes that fit and must cope with embarrassing remarks.

"I hated my body," says a woman in her late teens who had breast reduction. "From the time I was twelve, it seemed like every man I passed felt entitled to comment on my chest. The bra straps that dug into my shoulders were bad enough, but the comments were the worst." She went from wearing special-ordered bras to wearing a B cup. About five pounds of tissue was removed.

Area surgeons agree that women who have this surgery are among their most satisfied patients.

Breast reductions are more complicated than augmentations—they're performed under general anesthesia, transfusions are usually necessary, and hospital stays are common.

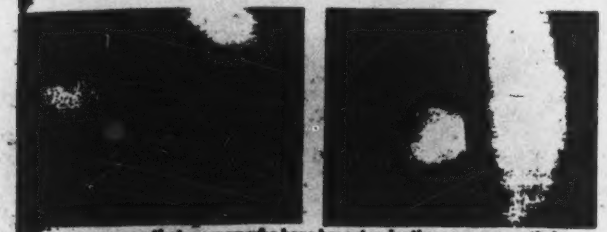
A keyhole-shaped incision is made in the breast, with the nipple in the center. The nipple is removed and repositioned upward, then fat, tissue, and skin are removed, and the edges of the now-smaller breast sewn back together.

After surgery, a dressing or a surgical bra is worn for a few days. Any lifting or overhead movement is uncomfortable. Women usually go back to work after two or three weeks.

One complication of breast reduction is that some women never regain sensitivity in their repositioned nipples. And a woman who intends to breast-feed should put off the surgery, because the milk ducts leading to the nipple will probably be severed.

Scarring is extensive, although the largest incision is hidden in the fold where the breast meets the chest wall. The incision lines around the nipple and the vertical line from the nipple to the chest wall, where the edges of the keyhole were joined, fade somewhat, but will always be visible.

Cost: $3,000 to $7,000 for the sur-



surgeons say that women who have breast reductions are among their most satisfied patients. But the operation is a complicated one, in which the nipple is removed, repositioned upward, and then fat, tissue, and skin are removed. Scarring is extensive.

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One method of hair replacement is punch grafting, where hair is taken from the back of the head and 40 to 80 clumps are transplanted to the front. It takes about three months to heal completely and not look spotty.

Micro grafts can be used to fill in the gaps of a grafted hairline for a more natural look.

geon's fee, plus anesthesia and hospital charges. Insurance may pay a portion of this if the surgery is to alleviate back pain or other medical problems.

Breast lift (mastopexy). If your breasts sag toward your waist, the breast lift may be the answer. It is similar to the breast-reduction operation.

This operation does not have a reputation for lasting over the long haul. Often the internal tissue does not hold its new shape and begins to sag again within five years, sometimes within months.

Cost: $3,000 to $6,000, plus any hospital or anesthesia charges.

Eyelid surgery (blepharoplasty). Remember how much better Rosalynn Carter looked after she had this operation? Droopy eyelids can make you look tired and old. Some people have bags under their eyes or sagging lids even in their twenties—it runs in families.

Excess folds of skin above the eye and pouches underneath are frequently excised in conjunction with a facelift. But sometimes the procedure is done by itself, especially in men. "Not everybody needs a full facelift, and if droopy skin and wrinkles around the eyes are what bother you most when you look in the mirror in the morning, that's what you go for," says Dr. Harvey Austin, a Virginia plastic surgeon.

The incisions follow the natural contour lines of the upper and lower lids. The surgeon cuts away sagging skin and loose muscle and suctions out any extra fat. The resulting hairline scars tend to fade in about two months.

If the operation is done alone, and not with a facelift, it is most often done under local anesthesia.

The operation seldom removes fine "laugh lines" at the outer edge of the eyelids, though they usually are greatly reduced. It also doesn't change the position of the brows, which is another surgical procedure.

The eye area is bruised and swollen for about two weeks. Patients often must keep their heads up, put cold compresses on their eyes periodically, and use antibiotic eyedrops for several days. The eyelids can feel stiff and sore for several weeks. Patients can't wear contact lenses for about two weeks; make-up can be used in about ten days.

Cost: about $3,000 to have both upper and lower eyelids done, plus any anesthesia or hospital fees.

Tummy tuck (abdominoplasty). Some people who are not seriously overweight in the rest of their bodies have bulgy stomachs. If the problem is too much fat, and the skin is still elastic and the underlying muscles in good shape, the problem can be corrected with liposuction.

But in some cases liposuction alone won't work. "If there is complete relaxation of the abdominal muscles and a lot of stretched skin, say from many pregnancies, a woman can work out and that will help some. But the muscle wall really needs to be repaired," says Dr. Bernard Tousis, a plastic surgeon with offices in McLean and Chevy Chase.

The operation that removes excess skin, fat, and muscle is the tummy tuck. People whose problem is just a flap of loose skin hanging down where they have lost a considerable amount of weight sometimes have a "mini tuck."

A tummy tuck, despite its cute name, is heavy-duty surgery. The navel often has to be repositioned or rebuilt, and the scar from the incision—all the way across the abdomen just above the pubic area—is large and permanent. The operation usually takes two to four hours and is done in a hospital under general

PHOTOGRAPHS COURTESY OF [illegible]

anesthesia. When patients wake up, they feel miserable.

Abdominal supporters must be worn for two to three months, and for the first few days the patient must stay in bed with hips bent to reduce tension on the abdomen. Although patients are up and about in a few days, they're not able to return to work for at least a week, and more likely two or more.

It is not uncommon for a hernia to be repaired at the same time abdominoplasty is done. One Virginia woman who had to have a hysterectomy decided that she might as well have a tummy tuck at the same time. "The worst part of the surgery was the logistics of finding a day when the general surgeon and the plastic surgeon could both operate," she says. She is very pleased with the smoother stomach that resulted. "A big thrill is that the stretch mark I had about two inches above my belly button is now two inches below it."

Cost: between $3,000 and $6,000, plus hospital and anesthesia charges.

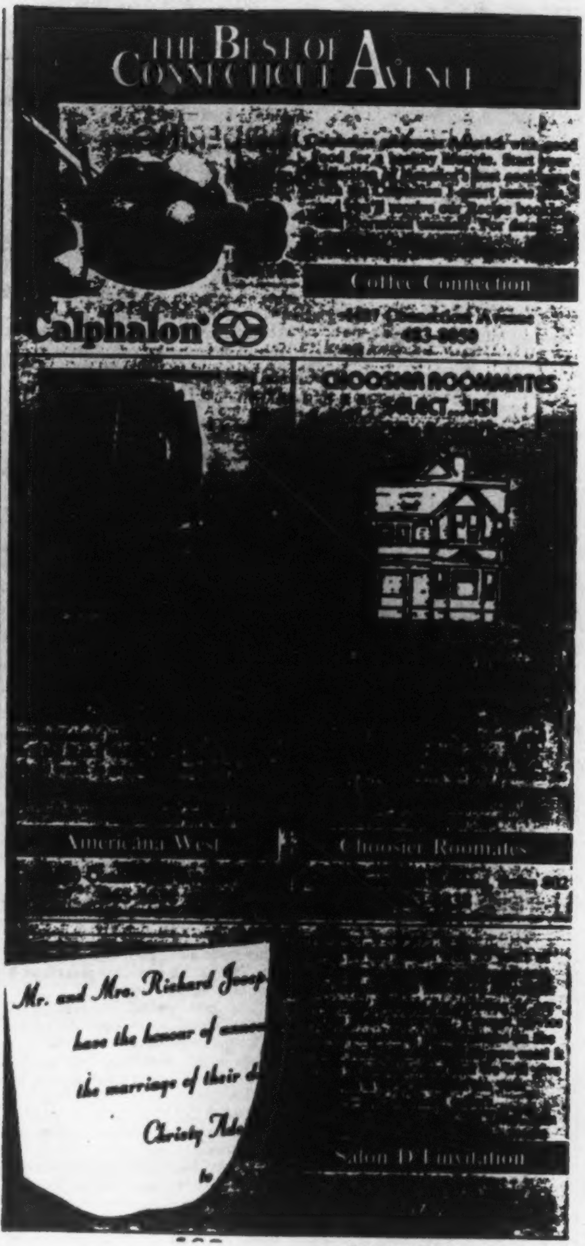
Chin augmentation (mentoplasty). This operation corrects a chin that is too small, too pointed, receding, or otherwise out of proportion with the rest of the face. About half of all patients who undergo nose surgery find they need chin surgery, because a prominent nose and a receding chin are sharing the same face. You just notice the nose more.

There are two types of cosmetic chin surgery. The first, which uses either a gel-filled or silicon implant, is the less traumatic. The doctor operates either through the inside of the mouth, which leaves no scarring, or, more commonly, through a one-to-two inch incision just under the chin, where scarring is seldom noticed. The insert is placed between the chin bone and the tissue. It takes about an hour and is done under a local anesthetic.

Chin-implant surgery normally involves so little trauma that there is hardly any swelling or bruising. Stitches are removed in five or six days. The chin is a bit numb, but not really sore, for about two weeks.

In some cases the surgeon may decide that the chin would best be augmented by repositioning the chin bone itself. This is a bigger operation, usually done under general anesthesia.

The surgeon (some oral, or dental, surgeons perform this operation) makes an incision within the mouth to access the chin bone. Then, using a saw or chisel, he makes a horizontal cut through the bone, moves the cut-off portion forward into its new position, and wires it into place. There is swelling and bruising of surrounding tissues, including the neck, after this operation. Because it takes about six months for all the swell-



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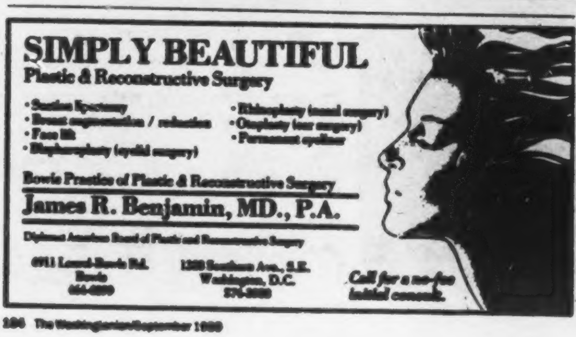

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ing to go away, the new chin won't be perfect until then; however, it will look fine to everyone else within a few weeks.

Chin surgery does wonders for a profile, but it does not correct an overbite or any other dental problems.

Cost: varies considerably, from $750 to $3,000 for the surgeon's fee, plus any hospital or anesthesia costs.

Hair replacement. It's hard to get a handle on how many of these procedures are being done, because hair replacement is performed by plastic surgeons, dermatologists, and other specialists. The key, as in any other surgery, is to find a doctor who does a lot of transplants.

The two most common procedures are punch grafts and scalp reduction. The latter, which is the newer of the two, is more dramatic, because it can do in one step what it might take two or three sets of grafts to achieve. The surgeon excises a wedge of bald skin, draws up the edges, and allows nature to take its course. The scalp feels tight for a few weeks, but then it will feel the way it did before. The result: The bald area is smaller. If the scalp heals well, the doctor might be able to perform several reductions. This technique only works in men with limited areas of baldness.

In punch grafting, the doctor takes hair from the back of the head, where it is usually still growing, then grafts in 40 to 80 tiny clumps where they are needed.

It takes about three months for the grafts to heal completely and begin growing new hair. One disadvantage to punch grafting is that everybody can see when someone is doing it, because the hairline looks so spotty. Mini and micro grafting in front and at the part can reduce this look, but success is determined by the skill of the doctor, the kind and amount of hair a man has, and where the bald patches are. Often hair can be styled to hide the grafts.

Who is the best candidate for hair grafting? "Gray-haired men do best of all; the grayer the better," says Dr. Jeffrey C. Weidig of Rockville, who is one of a handful of doctors in the country who do nothing but hair transplants. "The most important thing is that the men have good, reasonably dense areas of hair at the back and sides of the head in the donor areas," Weidig says. "It also helps if he's not terribly bald, and most men are not."

The worst candidates for either method is the man with just a ring of hair around his head at ear level. He doesn't have enough donor sites to make grafting a good bet, and you can't reduce that much scalp.

Weidig says that patients often come to him in their early thirties, when male pattern baldness is becoming noticeable, for an initial graft of 40 to 60 plugs.

"Then I may not see the patient again for another six or seven years," he says. "I'm following huge numbers of guys that way. The advantage to gradually doing treatments is that as they lose hair it's filled in, and they never go bald."

Both grafts and scalp reductions are done in the doctor's office, under local anesthesia. Figure at least a week off from work, because you'll look pretty awful. The grafts must be babied along—no strenuous exercise.

Cost: Hair transplants cost between $20 and $30 per plug, plus any associated costs. Reductions cost $1,000 and up, depending on the size of the reduction.

Forehead lift. This is generally done as part of a full facelift but can be performed separately. It used to be that the results didn't last very long, but now surgeons say the area won't sag again for five to ten years, maybe longer.

The forehead lift corrects drooping brows and heavy lids, giving a more youthful appearance. The operation is sometimes done on young adults whose eyebrows are so low that they have a perpetually sad or scowling expression.

The incision is made either across the top of the head, an inch or two behind the hairline, or at the base of the hairline. Extra skin is pulled upward and clipped off, and several strips of forehead muscle are removed—the change in the operation that makes it longer-lasting. If there are deep vertical furrows at the top of the nose, a bit of muscle may be snipped there, too.

The operation can be done under local or a general anesthesia. Bruising and swelling follow, but they begin to fade after about a week and are gone within a month. Stitches come out in a week to ten days, at which time most people feel like going back to work. The scalp feels numb for some time because nerves have been cut. In some rare cases the numbness is permanent.

Cost: $2,500 to $5,000 for the surgeon's fee, plus any hospital or anesthesia fees.

Ear pinning (otoplasty). Ear growth is complete by age five or six, so this surgery is often done on children.

Otoplasty makes large or prominent ears lie closer to the head. The surgeon cuts a wedge-shaped incision in the fan-shaped cartilage of the upper ear, then folds the cartilage back, and sutures it in position.

The procedure, which lasts a few hours, is usually performed in the doctor's office, using local anesthesia if the patient is an adult and general anesthesia if a child. The ears are covered with a bulky dressing, which stays on a few days. Lighter bandages may be necessary for several weeks to keep ears in place.

Cost: $1,000 to $4,000.

George F. Miller, M.D.   Vesna Mrzljak, M.D.

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[illegible]

Young Again!

How to Choose a Surgeon

Who Is Qualified to Do Cosmetic Surgery? Here's What to Look for—Plus, Doctors Who Do It Well.

By Salley Shannon

If you want to get rid of saddlebag thighs or your son would have preferred that Grandpa had passed along a trust fund rather than his nose, you won't have any trouble finding a doctor.

That's the problem.

There are so many area doctors performing cosmetic surgery that they are practically tripping over one another on the way to the operating room.

"Cosmetic surgery is a combustible area. It combines the American passion for looking good with the new technologies that make it possible," says Congressman Ron Wyden, who chairs a subcommittee of the House Small Business Committee, which has been investigating abuses in cosmetic surgery.

Wyden ticks off the reasons he feels it's difficult to know enough about a doctor: Most state regulatory boards won't tell you if a surgeon is under investigation or has been reprimanded for anything; certification doesn't mean as much anymore because new groups are passing out the "board-certified" tag; and the FTC doesn't regulate medical ads.

Although it is mostly board-certified plastic surgeons who do these operations, some otolaryngologists, or ear, nose, and throat specialists, do nose jobs and facelifts. Dermatologists do hair transplants. Dental surgeons operate on chins and jaws, even when the operation is cosmetic, not structural.

Plastic surgeons would prefer that other doctors clear out of what they consider their turf. They argue that they are the best trained. But some of the doctors who perform cosmetic procedures but aren't board-certified plastic surgeons are talented, ethical doctors. Fortunately, there are few charlatans in the area.

There are also some doctors with the right credentials, who, their peers tell you confidentially, are crummy surgeons. Not dangerous. Just not good enough. Colleagues don't turn them in. They just quietly redo their operations. And patients pay—in time, money, and anxiety—again.

Here are some guidelines for finding a surgeon who is right for you:

- Collect names from "all your friends who swear they haven't had anything done but you know they have," suggests Dr. Harvey Austin. Also ask your personal physician for a referral.
- The AMA-recognized American Society of Plastic and Reconstructive Surgeons has a toll-free number (800/635-0635) you can call to check credentials or get a list of ten members who practice near you. For surgery from the neck up, you can also call the Facial Plastic Surgery Information Service (842-4300 in DC or 800/332-FACE in Maryland and Virginia), which will give you names of three doctors in your zip-code area. Use these lists as starting points only. You should still investigate the doctors.
- Read *The Complete Book of Cosmetic Surgery* (Warner Books, 1988, $19.95), especially the chapters on choosing a doctor and judging the credibility of "before" and "after" pictures. It was written by local surgeon Elizabeth Morgan, now better known for her incarceration because of a visitation battle with her ex-husband over their daughter.
- Make appointments for consultations with one or two doctors—at most, three. Some doctors charge for this, some don't. This visit is to see if you're comfortable with the physician, and if your attitudes

Dr. [illegible], head of plastic surgery at *Arlington Hospital*, is shown here with the machine that has revolutionized fat removal. In liposuction, the pencil-thin, steel cannula is placed in a one-inch incision and moved up and down, breaking up the fat. *At* the same time, suction draws the fat cells out of the body and collects the yellowish-white mass in a jar.

[illegible]

One to two weeks after surgery, patients who come in to see Dr. Diane Colgan can have their bruises covered up with special concealers.

about what looks good agree!

- Be vigilant about checking the background of a doctor, especially in liposuction. Find out where a surgeon trained. Ask for patient references. Don't consider a doctor who has no formal training in any surgical specialty.
- Ask a surgeon how often he has performed the given procedure. Some doctors concentrate on noses or breasts. Choose the one who's done the best and the most of the procedure you want.
- Ask where a doctor is "on staff." Although most cosmetic surgery is now performed in doctors' offices, which can be as well equipped as hospitals, good doctors are still on staff at one or two hospitals. Forget any doctor who isn't.
- If your surgery is being done in an office operating suite, make sure the doctor has equipment to resuscitate you and breathe for you in an emergency.
- Never let money be the deciding factor. You need not pick the most expensive doctor, but if you can only afford the cheapest, hold off and save more money.
- Beware the hard sell. The best doctors wait for you to tell them what you think needs to be done; they don't make you feel as though surgery is your only alternative to wearing a sack over your head.

This list was compiled after three months of interviews—those named below were recommended repeatedly by their peers and former patients. Inclusion on this list is no guarantee that a doctor will be right for you. And there are many other competent physicians in the area.

The doctors listed here are board-certified in at least one surgical specialty by a board recognized by the AMA. Unless otherwise noted, the doctors perform many different cosmetic procedures.

Roger W. Anderson, 1801 Rockville Pk., Suite 616, Rockville; 770-6627.

Harvey W. Austin, 1776 Old Meadow Rd., McLean; 893-6168. Specializes in "rejuvenation" surgery, like eyelid tucks and facelifts.

James Benjamin, 1328 Southern Ave., SE, Suite 200, Washington; 574-3958.

Ronald R. Cameron, 11404 Old Georgetown Rd., Rockville; 468-1414.

Diane L. Colgan, 9800 Falls Rd., Suite 105, Potomac; 299-6644 (also an office in Olney).

Robert R. Conrad, 9715 Medical Center Dr., Rockville; 948-5670.

John A. Dowling, 10401 Old Georgetown Rd., Bethesda; 530-0700.

Jeffrey R. Hausfeld, 1145 19th St., NW, Suite 402; 466-7747 (also an office in Chevy Chase).

Steven B. Hopping, 1800 I St., NW; 347-2289 (also an office in Rockville).

John W. Little III, Georgetown University Hospital; 687-5751.

Ondie L. Hageney, 5454 Wisconsin Ave., Suite 1635, Chevy Chase; 657-1850 (also an office in McLean).

Mary H. McGrath, 2150 Pennsylvania Ave., NW, Suite 6B-422; 994-8141.

Lawrence B. McNeilly, 4810 North Beauregard St., Suite 203, Alexandria; 998-6570.

George Miller, 4900 Seminary Rd., Suite 201, Alexandria; 998-4111. Does neck and face procedures only, especially noses.

Talal A. Moussalli, 1715 N. George Mason Dr., Suite 102, Arlington; 841-0399.

G. Wesley Price, 3299 Woodburn Rd., Suite 490, Annandale; 560-2850.

Sharon Romm, Georgetown University Hospital; 687-8751.

Scott L. Spear, Georgetown University Hospital; 687-5751.

Bahman "Bach" Teimourian, 11125 Rockville Pk., Rockville; 881-6363 (also an office in Clinton).

Bernard S. Tomin, 5454 Wisconsin Ave., Suite, 1635, Chevy Chase; 657-1850 (also an office in McLean).

Jeffrey Weidig, 6243 Executive Blvd., Rockville; 468-2335. Performs only hair transplants.

George Weston, 1776 Old Meadow Rd., McLean; 893-6168. ☐

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A Pure Act of Flight

Continued from page 153

Louis—
Effective 15 May 1982 I resign as President. I am proud of what I have accomplished but it is time for new leadership.
J.N. Carsey

Nancy was dumbstruck. Each word out of Jenkins's mouth pierced. *This can't be happening,* she thought. *Sure the last year was tough—the federal budget cuts, the people who had to be laid off, the phone calls. . . . God, it was hard for both of us, for Jay especially. He'd never experienced failure. The college was his baby. He was everyone's golden boy, most of all mine. Graduation's in three days, we were looking forward to the summer, to getting away and doing things together. But this. . . .*

"I think you better check your mail," Louis said, breaking her trance.

Nancy was an unfamiliar figure at the tiny post office in Pomfret. As she fiddled with the combination to Box 35, her hands were shaking.

"Where's Doc?" It was Evelyn Coombs, the postmistress, surprised to see Nancy. Jay had always picked up the mail.

"Oh, he's out of town," Nancy said, trying to be nonchalant. The last thing she wanted was Evelyn Coombs trafficking in idle gossip.

There was a letter from the National Register of Historic Places (Green's Inheritance was a landmark house), an American Express bill, an electric bill, a color brochure from Neiman Marcus— and a letter from Washington, a letter from Jay.

> "I'm leaving because I know you can't. I am a physical and psychological disaster, and I don't want to drag you down with me."

Minutes later, sitting in the den off the kitchen where they spent so much of their time, where they had just had dinner two nights before, Nancy began to read:

N—
I'm leaving because I know you can't. I am a physical and psychological disaster, I have no will to improve, and I don't want to drag you down with me. When you feel emotionally able, there is a tape in the right-hand drawer of my desk that you should listen to.
J.

That wasn't all. There was another piece of paper in the envelope.

To whom it may concern:
15 May 1982

I hereby irrovably *[sic]*, and for the future, relinguish *[sic]* all claims to any assets and net worth relating to the estate of J.N. and N.S. Carsey. I also disclaim any responsibility for liabilities related to that estate.

This includes cash values of extant life insurance or annuity policies.

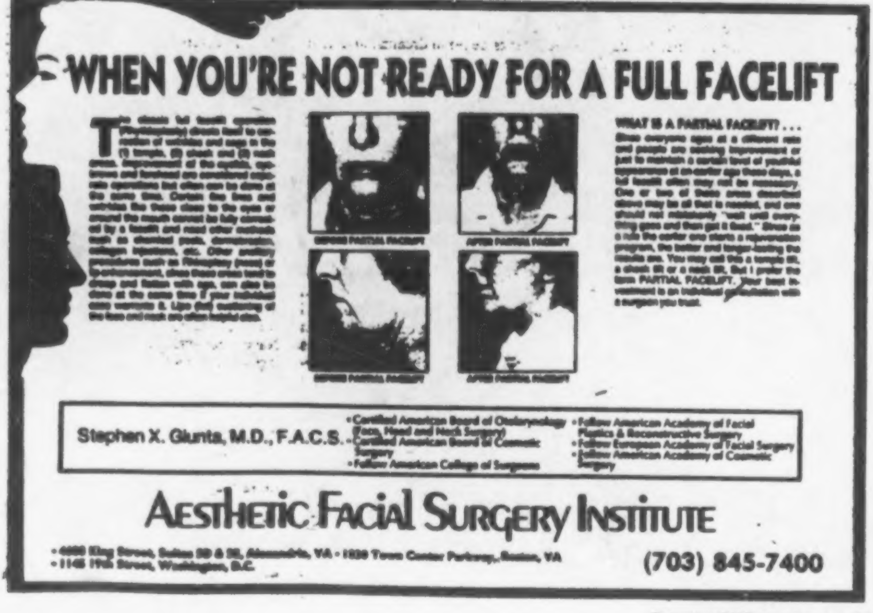
All properties assigned jointly or under my name singularly are Nancy S. Carsey's privileges to dispose of as she wishes.

J.N. Carsey

Holding one note in her hands, then the other, Nancy read them, and read them again.

John Sine got a postcard.

Sine had been dean of the college for seventeen years—as long as Jay had been president. They were friends, they played tennis together, they comple-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